THE HUMANE CONTAINMENT

OF

MENTALLY DISORDERED PRISONERS

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ABSTRACT

In many western countries, including New Zealand (NZ), the humane containment of mentally disordered prisoners (MDP) has became a topical issue in recent years. The current review of the literature demonstrated that there is little agreement regarding what measures are required to effectively address this somewhat complex matter and that there is a dearth of empirical research in this area, especially in NZ. The purpose of the current research was to empirically investigate this issue, within the framework of prisoners' rights in NZ, to ascertain whether there is an inherent gap between MDP's legal entitlements to mental health treatment (MHT) and the practical fulfilment of these rights. First, this was quantified by establishing an estimated base rate of clinically diagnosed MDP, and then by statistically verifying such persons' access to MHT via an in-depth analysis of both the detection and referral process and the treatment delivery system currently in operation to service the mental health needs of prisoners at a local medium security men's prison in NZ.

A randomised sample of one hundred medium security male inmates was obtained to ascertain a base rate of clinically MDP. Interviews were conducted, using the structured clinical interview for the DSM-III-R (SCID). The results showed that 62.8% of the final sample (n=94) had a clinically diagnosed disorder and that co-occurring disorders, especially substance use comorbidity, were prevailing issues. Analysis of the detection procedure involved a three-tiered examination; perusing the accuracy rate of detection, establishing what variables influenced a referral, and comparing these components with the referral process for rehabilitative MHT. The detection accuracy of participants with a substance use disorder was found to be significant, however, the detection rates of MDP and of participants requiring rehabilitative MHT for sexual or violent offence related issues were not found to function beyond the level of chance. Multivariate analysis revealed that visible signs of psychopathology, mental health history and atypical criminal characteristics increased the likelihood of detection. However, the majority of the MDP in this study were not detected. The examination of the treatment delivery system comprised a similar three-tiered analysis. The treatment delivery rate for MDP was not found to be statistical significant and neither was the overall delivery of rehabilitative MHT. Factors involved in treatment delivery were also explored and the findings collectively showed that the delivery of MHT for MDP primarily functioned as crisis intervention rather than humane containment. The practical implications of these research findings are discussed in relation to MDP's moral and legal entitlements to MHT and recommendations are made.

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Chapter One

THE LITERATURE REVIEW.

1.1. INTRODUCTION: THE RESEARCH PERSPECTIVE.

The humane containment of prisoners is an important human rights issue. One aspect of this issue which has received some attention over time is the provision of mental health services (MHS)[1] for mentally disordered prisoners (MDP)[2]. The decompensation of vulnerable individuals' mental health has long been attributed to the prison environment, especially with the added stress of overcrowding. The fundamental humanitarian concern in this regard has been the protection of such persons rights. However, the rights of prisoners is not a simple issue. The rights afforded to this population largely depends on the socio-political climate and context of a given society. While the issue of offenders' rights, especially prisoners' rights, is still a controversial issue, in New Zealand (NZ), in line with other western countries, prisoners have the right to be humanely contained and the availability of MHS for MDP is deemed an essential provision under humane containment requirements.

The plight of mentally disordered offenders (MDO)[3] has long been a prominent yet controversial issue. Because the mental health system and the criminal justice system (CJS) are involved in the social management of MDO, changes in either social system commonly draws attention to this "doubly deviant" group. The

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[1]Please note that MHS is used to notate mental health service and/or services.

[2]Please note that MDP is used to notate mentally disordered prisoner and/or prisoners.

[3]Please note that MDO is used to notate mentally disordered offender and/or offenders.

mental health twin policy of deinstitutionalisation and community care, which has been implemented in several western countries, including NZ, has heightened the attention paid to MDO by researchers, legislators, policy-makers and the public alike. While the majority of the interest has centred around *high profile MDO* (such as these found not guilty by reason of insanity), there has been a trickle down effect finally bringing the interest to the humane containment of MDP. The new wave of interest in this area, which relates to changes in both social systems, has raised concern that MDP' right to MHT is actually enforceable in real terms. However, there is a lack of comprehensive empirically based research in this area. More specifically, there is simply an absence of research in this regard in NZ, even though there has been comparable reform in this country as found overseas.

The aim of the current research is to investigate this important humanitarian issue in the NZ context. Clearly, the fundamental objective of research in this area is to ascertain what the situation is for MDP to aid the implementation of workable solutions at the practical level. While humanitarian concern has been the underlying impetus of this body of research, very few investigations have been conducted within the framework of prisoners' rights. This is probably because prisoners' rights are equivocal to say the least, however, research conducted within this framework is imperative for the implementation of practical solutions for the protection of this important human right. Therefore prisoners' rights constitutes the framework of the current study. The question addressed in this research is whether

there as a "gap" between MDP' paper and practical right to MHT under humane containment requirements.

1.1.1. AN OUTLINE OF THE REVIEW OF THE LITERATURE.

To establish whether there is a gap between MDP' paper right to MHT and the practical fulfilment of this right, the first issue that needs to be addressed is prisoners' rights to MHT. Because the issue of offenders' rights, especially prisoners' rights, is an equivocal and somewhat complex topic, the first three sections of this review provide a detailed discussion of this issue. In **section 1.2.** an outline of the key factors involved in this discourse is provided followed by a brief overview of changes in penal policy, with the emphasis on the NZ context. The influence such changes have had on offenders' rights is also discussed, with the emphasis on prisoners' rights. In **section 1.3.** the use of imprisonment is perused in more detail in relation to the current social climate, penal policy, and prisoners' right to MHT. This is followed by a more detailed look at the legal framework depicting prisoners' right to MHT. Upon establishing the legal framework of MDP' entitlement to MHT, it is then necessary to investigate the assertion that there is a gap between prisoners' paper and practical rights. This issue is examined in **section 1.4.**, and primarily looks at the inherent difficulties in policing the fulfilment of entitlements (or positive form of rights).

The next three sections address the practical issue of fulfilling MDP' right to MHT. The first question at the practical level is how many MDO, who are entitled to MHT, reside in prison. This issue is addressed in **section 1.5.**, where the research investigating prevalence rates is reviewed. The next step in the protection of

this right is the identification system. Therefore the detection and referral procedure found within prisons is reviewed in **section 1.6.**, to ascertain whether this system appears to provide MDP with the appropriate access to MHS. The provision of MHT is clearly the final step in the fulfilment of MDP' rights and this is reviewed in **section 1.7.**. The emphasis in this part of the discussion is on the delivery of treatment as opposed to the availability of MHS.

The plethora of research investigating the plight of MDO that has emerged following the implementation of the mental health twin policy, suggest that there is an increase in the number of mentally disordered persons residing in penal custody post-deinstitutionalisation[4]. This accentuates the importance of the practical fulfilment of MDP' right to MHT. Therefore, in **section 1.8.**, the literature investigating the relevant changes in the mental health system and CJS are briefly reviewed and the pertinent research findings are discussed in relation to the NZ context. Finally, in **section 1.9.**, a comprehensive summary of the literature review is provided, followed by an outline of the current research objectives and aims.

1.2. CONVICTED OFFENDERS' RIGHTS: AN INTRODUCTION.

What rights offenders do have or should have has long been a controversial issue in most common law based societies. It is evident that law and order are imperative for the existence of any human society and that the prohibition of certain social behaviours

[4]It is important to note that there is evidence which indicates that deinstitutionalisation has had a significant impact on intellectually handicapped persons and that such persons are also vulnerable to coming in contact with the CJS. However, this is outside the scope of this research.

as "criminal" is essential for the protection of society, and that this functions as the paramount form of social control (Bartol, 1991). The crux of the controversy is that, while this *police power* function is paramount for the protection of all citizen's rights, the coercive power that the state can exert via the CJS can dictate, in part, the type of social freedom available at the broader social level (Newbold, 1992). More specifically; what is defined as criminal deviancy; the arresting power of the police; the nature of the judicial process; and the type of penalties imposed; are some of the many factors that determine; the degree of autonomy afforded to citizens, the categorisation of offenders, and such persons' rights (Prins, 1980). Manifestly, the issue of offenders' rights is far from clear-cut, as this is but one of the many aspects involved in the continual social discourse regarding the social control of criminal deviancy. The purpose of this section is to provide a brief overview of the most pertinent factors involved in this discourse, to depict the broader contextual framework of prisoners' rights. The germane areas perused in this section are; convicted offenders, human rights, and the use of imprisonment. First, the fundamental dynamics involved in the issue of offenders' rights are elucidated. To demarcate the current approach toward offenders, this is followed by a summary of reform within the CJS in NZ leading up to the present day, and how this compares with other western countries.

1.2.1. DO CONVICTED OFFENDERS HAVE RIGHTS?: THE MORAL DILEMMA.

Deep-rooted in western culture is the moral concept of natural law which holds that there is a perfect **justice** in nature that should be emulated by the law governing society (Bartol, 1991; Oxford

Reference: A Dictionary of Law, 1994; Prins, 1980). In most common law based societies this concept is fundamental to all law, whereby the ultimate aim of the law is to uphold "justice" which, in the simplest of terms, constitutes the protection of rights and the punishment of wrongs (Barbara Hudson, 1987). In essence criminal deviancy is behaviour that is largely condemned and is viewed to threaten the safety of the community; such as that which poses a threat to the immediate safety of persons, or to the social stability and/or the societal structure (Barbara Hudson, 1987; Newbold, 1992; Western, 1991). This means that an offender, by committing the said offence (or public wrong), has thereby impinged on the rights of others, either directly or indirectly depending on the type of act. Subsequently, in accord with this concept of justice, such persons are lawfully subject to punishment, not only for the protection of society but also to avenge these public wrongs (Bartol, 1991; Barbara Hudson, 1987). Clearly, an offender is deemed to have relinquished some degree of his/her rights by committing the alleged offence. While the rights of offenders have traditionally been viewed as secondary to that of public safety and social retribution, the long-standing moral dilemma is the extent to which offenders' rights can **justifiably** be denied.

Proportionality in Sentencing. Although there is the necessity for the provision of public safety and there is invariably the social demand for retribution, this has historically been matched with the demand for *fair play* (Prins, 1980; Treverton-Jones, 1989). The rules of fair play or natural justice[5], function as the governing

[5]Otherwise referred to as fundamental fairness, fundamental justice or due-process.

measure of equity within the legal system and, in simple terms, the principles of natural justice hold that the law must be impartial to be valid (Prins, 1980; Shah, 1993). While these principles are fundamental to the judicial proceedings, the issue of fair play is of equal importance throughout the criminal justice process (CJP). What is pertinent to this discussion is the issue of proportionality in sentencing. Offenders are a heterogeneous group; not only is there the important distinction between alleged and convicted offenders, but there are also many acts prohibited under the criminal statutes which vary widely in nature and severity (Bartol, 1991; Newbold, 1992; Western, 1991). Manifestly, the need for societal protection and the demand for retribution primarily differs in relation to the type of offence committed. It has long been asserted on the grounds of fair play, that the gravity of the punishment imposed should match (but not exceed) the seriousness of the crime committed and hence the threat that such behaviour presents to the community (Bartol, 1990; Prins, 1980). In other words, the punishment and subsequent denial of rights, should be proportionate to the said offence. This means that the deprivation of rights over and above the punishment imposed and the associated forfeiture of rights constitutes an arbitrary denial of rights (Barbara Hudson, 1987; Prins, 1980; Treverton-Jones, 1989). Clearly then, the deprivation of convicted offenders' rights is integral to the concept of proportionality in sentencing. In other words, the arbitrary denial of rights is considered unconstitutional because it constitutes disproportionate punishment which in turn contravenes natural justice principles.

Human Rights. The denial of offenders' human rights is one area that has long been a matter of debate under the issue of fair play and has also historically been contested as *unconstitutional* from a humanistic perspective at the broader societal level (Prins, 1980; Treverton-Jones, 1989). It is via the basic premise of natural law that human beings are deemed to have rights per se, that subsequently warrant legal protection. In simple terms there are civil rights; which are those defined through the law of the given community, and then there are natural or human rights; which are those that are considered to be fundamental to persons and are therefore deemed to exist independently from "man-made" law (Prins, 1980; Brody, 1988). The long-standing dispute is that human rights clearly warrant superlative legal protection given the inherent nature of such rights. Manifestly the apparent arbitrary denial of offenders' basic human rights has historically been subject to avid scrutiny and contention under the issue of fair play, on the grounds that any human suffering that supersedes the said punishment imposed is *cruel and inhumane* and unconstitutional (Bartol, 1991; Barbara Hudson, 1987; Prins, 1980; Treverton-Jones, 1989). The deep-rooted nature of this humanitarian demand for commensurability in the imposition of penalties is highlighted by the English Bill of Rights 1688, which prohibited the application of "cruell and unusuall" punishment (Treverton-Jones, 1989). Moreover, in accordance with the more holistic humanistic perspective, human rights are viewed more as *inalienable rights* as opposed to fundamental entitlements. Subsequently, it has been asserted on these grounds that such rights **cannot** constitutionally be denied under "man-made" law. From this position, the use of barbaric forms of punishment has

long been argued as a contravention of the basic premise of natural law due to the integral deprivation of offenders' human rights, making this form of punishment unconstitutional (Barbara Hudson, 1987; Prins, 1980; Treverton-Jones, 1989).

Closing Comment. Clearly then, in most common law based societies, it has long been asserted that offenders have **not** exclusively forfeited all rights, with the issue of offenders' human rights being the most pertinent point of contention. What rights are afforded to offenders by the state is a reasonably complex matter, however, primarily because the concepts of justice and fairness evoke subjective value judgements. For example, the issue of human beings' fundamental or human rights is by and large a western concept, nevertheless, even within the western context there is some disparity between countries and jurisdictions in the emphasis placed on the inalienability of such rights under penal policy. Evidently, the cultural context and the political arrangement of a nation largely dictates the significance attributed to individuals' rights in relation to the cultural collective (Newbold, 1992; Shah, 1993). Moreover, changes in the social attitude, knowledge and tolerance of certain behaviours can produce subsequent shifts in the somewhat fuzzy boundaries defining social deviancy, justice and rights (Bartol, 1990; Greenberg & Bailey, 1994). Manifestly, what is deemed to constitute an equitable form of coercive state intervention and thus the extent to which offenders' rights are denied, especially with respect to punitive sanctions, not only depends on the national context but also on the socio-political climate at a given point in time (Barbara Hudson, 1987; Prins, 1980; Shah, 1993).

1.2.2. PUNISHMENT AND EQUITY: A BRIEF HISTORICAL OVERVIEW.

As highlighted in section 1.2.1., the types of penalties imposed is an integral determinant in what constitutes convicted offenders' rights per se. While sentencing policies are largely contingent on the issue of proportionality, the broader social values advocated by the given community primarily determine the type of punitive sanctions utilised under penal policy. In most western countries, with changing social attitudes towards offenders and crime, in conjunction with other socio-political factors, there has been cyclic reform in the CJS in the effort to obtain an equitable means of controlling criminal behaviour (Barbara Hudson, 1987). In NZ, in accord with other western countries, the contemporary CJS is a direct result of past attempts at reform, having evolved to execute the dual function of protecting the collective rights of citizens, especially that of public safety, and protecting the individual rights of offenders (Durham, 1989; NZ Penal Policy Review Committee, 1982; NZ Department of Justice, 1988; 1989). It is an apparent imbalance in the provision of either function that commonly precipitates the demand for reform in this social system. In simple terms, the primary interactive equity measures of punitive sanctions have become; humanitarianism, proportionality and effectiveness.

Why Punishment? Given that social retribution is integral to the moral concept of justice, it is not surprising that punitive action has been the most common means utilised to control criminal deviancy. The traditional social attitude toward offenders has been that such persons are evil and/or sick social deviants largely because behaviour that threatens the immediate physical safety of

persons, or in other words moral wrongs, have commonly been denounced as "criminal" conduct. In conjunction with the "eye for eye" approach to proportionality, this attitude has allowed for the enforcement of barbaric forms of punishment over time (Bartol, 1991; Barbara Hudson, 1987; NZ Department of Justice, 1988; Treverton-Jones, 1989). The multifaceted rationale for the use of punishment, which is still applicable today, holds that the threat of punishment will provide a general deterrence from criminal activity for the protection of the community. More directly, the imposition of punishment is seen to provide a specific penalty and deterrence, giving credence to the penal system and reinforcing the first proviso. Finally, punitive action is seen to fulfil the social demand for retribution and to appropriately denunciate crime (Barbara Hudson, 1987; NZ Penal Policy Review Committee, 1982; NZ Department of Justice, 1989). It is important to note, however, that irrespective of the basic philosophical orientation of the penal system, the fundamental aim is to reduce (or ideally eradicate) criminal deviancy for the protection of the community. This means that, while the provision of public safety is paramount, the state is duty bound to employ methods of intervention that are both effective in reducing criminal behaviour and congruent with the values of the given community. The efficiency of the intervention utilised is not only measured by the degree of public safety provided, but also by the costs and benefits yielded at the fiscal and social levels within the community (Barbara Hudson,1987; NZ Law Commission, 1994).

The Emanation of Prisons. In the early eighteen hundreds, promptly following the European colonisation of NZ, penal policy was quickly

established and the major penalties were; execution, transportation and imprisonment. In accord with other western countries, the early NZ gaols were primarily used to contain; alleged offenders, offenders convicted of committed minor offences and convicted serious offenders awaiting transportation or execution. Emulating English history, with the abolishment of transportation in 1855 in this country, NZ was forced to re-evaluate the management of serious offenders. The penalty of penal servitude replaced that of transportation, which meant that, for the first time in this country, prisons were required for the containment and punishment of serious offenders. Over the following few decades the deficiencies of prisons in NZ were the topic of reasonable debate, involving such issues as; the lack of security, overcrowding, poor treatment of inmates, and the inconsistent management found between these institutions (NZ Penal Policy Review Committee, 1982; NZ Department of Justice, 1988; 1989).

The Reformist Approach. Finally, as a result of elevated political concern and with the control of prisons under central government, Captain Hume was imported from England and was appointed as Inspector of Prisons in 1880 to amend the penal system in this country. Hume brought with him an approach to penal philosophy based on over thirty years experience within the prison system in England (NZ Department of Justice, 1988). Early in the nineteenth century in England and America, the reformist ideology was widely embraced within society. This humanitarian based philosophy held that social deviants were primarily socially disadvantaged persons, rather than deviants per se, who fundamentally required

moral treatment by society to become productive social members. Across countries, this was widely seen as a moral solution to the growing social dissonance with the increasing deviant population (Durham, 1989; Morrissey & Goldman, 1986). By firmly establishing the state's *parens patriae* duty, or in other words the state's responsibility to **provide** for its citizens (including social deviants), the amalgamation of this ideology within the social infrastructure was the first significant shift away from the dehumanising approach toward offenders. In England, as found in America, the reformist ideology was readily assimilated into penal policy. It was held that, while some offenders were incorrigible, most offenders could be reformed through humane containment and moral treatment, affirming that the state had the moral responsibility to employ humanitarian based measures to accommodate offenders (Barbara Hudson, 1987).

Although Hume took a disciplinarian approach towards reformation, it was via his policy reform that the additional objective of reforming offenders (where possible) became a function of penal sanctions in this country. This ideology was centred around the use of imprisonment and Hume's policy reform saw the development of the prison system, which resolutely instituted incarceration as the primary component of the penal system in NZ. This development in penal policy was humanitarian based and was implemented with admirable intentions. However, it would be erroneous to say that the treatment of prisoners or that the conditions of prisons were humane. While reforming offenders was the underlying goal of imprisonment for the majority of inmates, this was pursued within a predominantly punitive framework

which generated considerable conflict regarding reformist goals. Moreover, the trend found across countries was that prison populations were progressively increasing which, in conjunction with other socio-political factors, inhibited the implementation of certain policy objectives (NZ Penal Policy Review Committee, 1982; NZ Department of Justice, 1988; 1989).

The Rehabilitative Approach. In this country, in line with other western nations, the second most important change in penal history did not occur until after the second world war. Across countries, the exposure to the atrocities of this war, produced a compelling degree of social introspection in relation to the societal treatment of citizens. This brought a renewed humanitarian approach towards social deviants, which produced social support for a de-emphasis on social retribution in favour of the utilisation of effective, yet humane, intervention. This became the ideal climate for the rejuvenation of the reformist approach to criminal behaviour. Under this newly founded rehabilitative approach, the reformation of inmates was centred around educative means rather than through the value of the "work ethic", as found under the reformist approach of last century (Barbara Hudson,1987; NZ Penal Policy Review Committee, 1982). In addition, the overlap between the behavioural boundaries defining criminality and mental abnormality, which has long been acknowledged, was addressed under this new approach (Bartol, 1991). It is held under this revived reformist approach that offending behaviour is not only be a product of social and/or environmental factors but can also be a result of offenders' psychological problems (Barbara Hudson,1987). According to this

approach, certain types of crimes are considered to have a psychological basis, such as sex crimes, and some offenders are considered to have psychological disturbances that influence offending behaviour, such as substance use problems. Therefore, in addition to basic scholastic education and job training skills emphasised under this approach, MHT programmes were also widely employed for rehabilitative purposes (NZ Department of Justice, 1988; 1989). The use of indeterminate sentencing was also validated under this philosophy, on the grounds that notable protection was required from the incorrigible, while the corrigible needed time to reform. Although the use of indeterminate sentencing was not as pronounced in this country as compared to the US, this practice was endorsed under the Criminal Justice Act 1954, largely mirroring English law (NZ Department of Justice, 1982; 1989).

Offenders' Rights. In conjunction with social pressure to re-evaluate penal philosophy, this growth in moral consciousness also brought forth a move to protect custodial offenders' basic human rights. There was accelerated growth in the demand for a "legalistic" model of rights, with particular emphasis on the issue of human rights. The primary goal was to provide better legal mechanisms to protect persons from rights infringements. The scale of unification in this regard is exemplified by the establishment of the Universal Declaration of Human Rights in 1948 under the new United Nations (Brody, 1988). This has been followed by additional and more specific documents, most pertinently, the United Nations Standard Minimum Rules for the Treatment of Prisoners (1955). The establishment of this

document, which specifies prisoners' basic human rights, reflected the widely felt social dissatisfaction across countries with the social control of criminal deviancy, most notably, the deprivation of offenders' rights. S. T. Barnett, the Secretary of Justice in NZ during this era, was instrumental in the substantiation of the Penal Institutions Act 1954, which corresponded with internationally recognised standards. It was via this Act that a system of human resources was affirmed as a necessary provision for custodial offenders, where Barnett promoted the development of the prison medical service and initiated the deployment of psychologists and chaplains for prison populations (NZ Penal Policy Review Committee, 1982).

A De-emphasis on Imprisonment. By the late 1950's to early 1960's further reform was sought across countries. The pressure for the denunciation of "inhumane" forms of punitive action had gained ground by this time. Not surprisingly, the utilisation of the death penalty was reproached as excessively restrictive and inhumane. Serious questions were also raised regarding the equity of the penalty of imprisonment and its utilisation, due to the growing demand for penal institutions and disquiet found within penal institutions (NZ Penal Policy Review Committee, 1982). Across countries, there was renewed humanitarian concern that the conditions of prisons did not generally meet with international human rights standards. In NZ, in accord with other western countries, the majority of prisons were considered antiquated and were commonly found to be overcrowded, placing offenders at risk of human rights infringements (NZ Penal Policy Review Committee, 1982; NZ Department of Justice, 1988). The use of indeterminate

sentencing also came under particular criticism during this time, because the indefinite nature of this type of sentence was argued to contravene the principles of fair play (Barbara Hudson, 1987; NZ Penal Policy Review Committee, 1982). Likewise, the validity of this type of penalty was readdressed regarding its effectiveness as a punishment. Across countries, including NZ, the persistent level of criminal behaviour, in conjunction with a high re-offending rate of ex-prisoners gave support for the argument that imprisonment is generally an ineffective means of deterring criminal behaviour and protecting society (Barbara Hudson,1987; NZ Department of Justice, 1989; Severson, 1992; Treverton-Jones, 1989). Another factor to consider was that the containment of offenders in penal custody places an immense drain on social resources. Subsequently, there was considerable support found across countries to establish an equitable alternative to incarceration (NZ Department of Justice, 1988; Severson, 1992; van Zyl Smit & Dünkel, 1991).

Last Resort. In accord with internationally recognised human rights principles, it was widely argued that the least restrictive option should be employed to fulfil legitimate societal objectives (Dawson, 1984; NZ Penal Policy Review Committee, 1982; Wardlaw, 1983). Although the utilisation of imprisonment had been reproached on multiple grounds, it was widely accepted that incarceration still served the vital function of incapacitation for the provision of immediate public safety, for which there was and still is no humane alternative. Therefore, in accordance with the "least restrictive option" principle, it was asserted that incarceration should be used as a *last resort* for serious offenders

and non-custodial options should be utilised where possible (Dawson, 1984; Barbara Hudson, 1987). In other words, within the bounds of the law, the court should only impose a sentence of imprisonment if it is deemed essential for the protection of society. This approach is in line with the view expressed by Barnett in the early 1950's in NZ. Barnett was concerned that there was a considerable number of offenders in custody, who in his view, posed little threat to the immediate safety of the community. He questioned the validity of detaining such offenders and sought non-custodial penalties for less serious offenders in NZ (NZ Department of Justice, 1989). With this new wave of dissatisfaction, in line with other western countries, it was affirmed under NZ penal policy that incarceration should be used as a last resort (Barbara Hudson,1987; NZ Department of Justice, 1989). Therefore, across several western nations, the endorsement of this policy brought a de-emphasis on the use of imprisonment, which required comprehensive initiatives for non-custodial alternatives for less serious offenders. The result of this move for change was the implementation of a more dynamic humanitarian based rehabilitative approach. Following England's lead, the death penalty was finally abolished in 1961 in this country. The Minister of Justice, Mr. Hanan, and the Secretary of Justice, Dr. Robson, also set out to reduce prison populations, while aiming to increase the rehabilitation rate of offenders. Reflecting trends found in England and Australia in the 1960's, in this country over this time period; the use of indeterminate sentencing was minimised, there was an endeavour to "normalise" the prison environment for rehabilitative purposes, and mechanisms were implemented to enforce the last resort policy,

such as; a broader application of probation services, a more extensive deployment of non-custodial penalties, including options such as; fines, periodic detention and supervision, and an increase in the use of parole options (NZ Penal Policy Review Committee, 1982; NZ Department of Justice, 1988; 1989).

The Rehabilitation Backlash. The primary focus of reform from the late 1940's through to the early 1970's, was the humane treatment of offenders and the protection of such persons' rights. From the 1970's onwards, however, there has been growing public discontentment with the progressively increasing rate of crime and the subsequent lack of public safety. Across countries, given the apparent ineffectiveness of the rehabilitative aim of the CJS, it is not surprising that there was a backlash against this approach. From the conservative perspective, it was widely argued that due to rehabilitative philosophy, the CJS had inappropriately become an arena where all social "injustices" are addressed (Barbara Hudson,1987). In accord with this more hard-line approach to crime it has been argued that, due to the ineffectiveness of the rehabilitative aim, this objective should be dropped as a goal of criminal penalties and the demand for social retribution should be reaffirmed within policy as the central objective. This would mean that the aim of punitive sanctions would solely be punishment and deterrence, which is argued to ensure that the CJS is more efficient as it would be seen as a more credible means of social control (Barbara Hudson,1987). The rehabilitative aim has also received a reasonable degree of criticism for the liberal movement (Barbara Hudson,1987; NZ Penal Policy Review Committee, 1982). Several measures employed

under the name of rehabilitation have been refuted as cruel and inhumane from the liberal perspective. As already discussed, indeterminate sentencing was widely viewed as a disproportionate punishment and unconstitutional. The utilisation of MHT for the rehabilitation of offenders has also received serious criticism from opposing perspectives. An argument from the liberal perspective which is still prominent today, is that due to the nature of this form of intervention, rehabilitative MHT can often be more intrusive than alternative penalties. Although offenders can decline treatment offered, it is argued that offenders do not really have this option given the weight commonly placed on compliance with treatment recommendations within the CJP (Barbara Hudson, 1987; Western, 1991). It was argued from the conservative approach that an inquiry into the mental health status of offenders for rehabilitative purposes allows for considerable confusion regarding the issue of criminal responsibility (Barbara Hudson,1987). During this time Martinson (1974) studied a selection of rehabilitative MHT measures. He concluded from his findings that "nothing works", which provided further support for the move away from the rehabilitative approach in this regard (Bartol, 1991; McLaren, 1992; Pelissier, 1988). Given that this ideology has been disparaged from both conservative and liberal schools of thought, policy reform with a de-emphasis on rehabilitation was imminent (Barbara Hudson, 1987).

The Justice Model. The "justice" or "just deserts" model of penal policy is what emerged from the backlash against the rehabilitative approach. In essence, this approach simply

reaffirms that the principles of natural justice should be central to sentencing and penal policies. Because of the broadly shaped nature of this approach, it has received reasonable support from liberal and conservative approaches to crime and it has had a significant influence in penal reform over these last few decades, in several western countries (Barbara Hudson,1987; NZ Penal Policy Review Committee, 1982). More conservative objectives have been dominant in penal reform under the justice model due the high degree of social pressure for better public safety measures. Nevertheless, the slant towards a conservative approach to crime has varied across countries and jurisdictions. A review of NZ penal policy was undertaken in 1981 to address the prospect of reform and the recommendations put forth played a central role in the passing of the Criminal Justice Act 1985 (NZ Department of Justice, 1988). Although this 1981 inquiry took a more liberal approach toward the "justice" model than other countries, such as the US, central elements are comparable. In line with other western countries it held that, while public safety provisions are paramount, the principle of last resort is still an essential policy objective. The view taken in this 1981 review was that public safety levels could be improved without revoking essential provisions endorsed for the protection of offender's rights under previous reform. The policy advocated by the Penal Review Committee 1981 was a *reintegration* based approach. In accord with other countries, this involved a more hard-line approach towards serious offenders for the protection of the community, broadening the availability of parole options to reduce prison numbers, while adding further non-custodial options, such as community service, for less serious offenders, and included an

emphasis on reparation for the victims of crime (NZ Penal Policy Review Committee, 1982).

The validity of rehabilitative objectives was not totally discounted under this wave of policy reform. While the use of indeterminate sentencing had largely lost favour in most countries, the rehabilitative goal of the CJS was still widely viewed as an important policy aim. This psychosocial approach toward offending had become integral to penal policy and the utilisation of MHT for rehabilitation purposes was not easily revoked by the "nothing works" claim (Barbara Hudson, 1987). A wealth of investigative research has been undertaken in response to the backlash against rehabilitative MHT, especially with regards to Martinson's assertion (McLaren, 1992; Pelissier, 1988). As summarised by McLaren (1992) in her review the research, the evidence shows that some treatment programmes are effective in curbing the behaviour of particular types of offenders and/or certain types of offending behaviour. For example, certain treatment procedures addressing areas such as; sexual deviancy, alcohol and drug problems, self-esteem issues, anger management problems and habitual offending, have been found to be effective rehabilitative measures (Bakker, Riley, Deely, O'Malley, Green & S. Hudson, unpublished, 1993; Belfrage, 1991; NZ Department of Justice Psychological Services, 1993; Rogers & Webster, 1989). This means that the state is morally required to employ such methods for the mutual benefit of offenders and the community. Therefore, in accord with other western countries, the NZ penal policy review (1982) recommended that the rehabilitative aim of the CJS should be retained under the reintegration approach, with

special emphasis placed on the deployment of rehabilitative MHT. The major difference between the rehabilitative and reintegrative policy objective for the utilisation of MHT is that there was less emphasis placed on the curative aspect of rehabilitative treatment, with a more stringent criteria for treatment delivery, based on the likelihood of recidivism reduction (Barbara Hudson, 1987; NZ Department of Justice, 1989).

Closing Comment. Changes implemented since the endorsement of the "justice model", which will be elucidated in the following section, have been of a similar vein in this country as found in other western nations. What has been evidenced here is that via the process of ongoing reform, important changes have been implemented in the quest to find an amenable method of controlling criminal deviancy. While there has been an emphasis on public safety issues as opposed to offenders rights since the 1970's, important policies and standards endorsed prior to this time have not been revoked. Although the degree of support for rehabilitative objectives have fluctuated over time, the goal of rehabilitation is still widely held as a beneficial policy objective. More pertinently, the internationally set standards for the treatment of prisoners and the policy of last resort have been retained under the justice model of penal reform which are essential for the protection of convicted offenders rights. What this means is that, under policy at least, the usage of imprisonment is still widely deemed to be incongruent with the accepted measures of equity. Nevertheless, imprisonment still serves the important function of incapacitation. Therefore, in most western countries and jurisdictions a term of imprisonment

is reserved for serious offenders/offences, while a variety of non-custodial options is available for less serious offenders.

1.2.3. SECTION SUMMARY.

It is apparent that the issue of convicted offenders' rights is a reasonably complex matter as there are several interrelated factors that determine the rights afforded to this population. Nevertheless, in most common law based societies, it has historically been asserted that the denial of offenders' rights should be contingent on the moral concept of natural law and should also be governed by the rules of fair play, both of which function as the foundation of the contemporary CJS. What this means is that the protection of offenders' rights, especially human rights, has long been a primary function of the CJS, equal to the provision of public safety and social retribution. The types of penalties utilised by the state via the CJS, largely determine the rights afforded to convicted offenders. Through the growth of moral consciousness and changing social attitudes there have been several changes in the types of penalties utilised. Across western countries, there has been a significant move away from the use of barbaric forms of punishment and an increased emphasis placed on the importance of *due process* in sentencing practices. The rights afforded to convicted offenders have clearly improved over time as a result of these changes. Across most western nations the denial of offenders' basic human rights is widely denounced and the internationally recognised "least restrictive option" principle has widely been endorsed, as reflected in the penalties currently available to the courts. Manifestly, the denial of convicted offenders' basic human rights is commonly deemed

unconstitutional and the majority of such offenders are afforded their liberty. However, imprisonment still serves a necessary social function which means that the conditions of prisons and the matter of prisoners' rights still constitutes an important penal and human rights issue.

1.3. IMPRISONMENT: POLICY, PRACTICE AND RIGHTS.

As evidenced in the preceding section, in NZ, in line with other western countries, there has been continual penal reform in response to the social climate and that it is this, in conjunction with the social context, that dictates the rights afforded to convicted offenders. While convicted offenders' rights have greatly improved over time due to changes in the types of penalties imposed, the problem of crime has not satisfactorily altered to stop or slow down the public demand for further reform. In line with the public pressure for reform since the 1970's, the contemporary demand has been for further improvements in public safety. The level of public pressure and the nature of the current climate brings to question the stability of the "least restrictive option" principle and that of the rights currently afforded to convicted offenders, especially regarding the de-emphasis on the denial of liberty as a punishment. What can be ascertained from the previous section is that, while prisoners' rights has long been an issue of concern, the primary focus of penal reform has been the utilisation of imprisonment rather than rights per se. The level of social concern regarding public safety levels brings to question the permanency of the move away from the use of imprisonment. Clearly then, the issue of prisoners' rights is an important contemporary matter. The area of prisoners' rights that is pertinent to this discussion is prisoners' legal entitlement to MHS.

What follows is an overview of the use of imprisonment in relation to the current social climate, with special regard to the issue of current crime rates and overcrowding in penal institutions. This leads into the importance of prisoners' entitlement to MHS. While the equivocality of prisoners' rights is considered in the following section, the current objective is to verify the legal framework of prisoners' **right** to MHT.

1.3.1. IMPRISONMENT AND THE CURRENT SOCIAL CLIMATE.

The denunciation of imprisonment as an equitable penalty constitutes one of the most important changes in penal reform for the protection of convicted offenders' rights. To recap, imprisonment has been found to be ineffective given the high rate of recidivism; has been deemed inhumane due to the age of most penal institutions and the problem of overcrowding; and has also been argued to contravene the rule of proportionality due to the risk of human rights infringements. These issues are still relevant today. In the US recidivism rates of ex-prisoners have been reported to be as high as 62.5% (Severson, 1992). In NZ recidivism has been reported to exceed that found in the US by over 15% (South Canterbury News, 23/8/95). Western (1991), for example, reported that around three out of four prisoners are found to re-offend in this country. The antiquated nature of prisons continues to receive media attention. In this country, for example, the state of Mt. Eden Prison in Auckland has been reported as barbaric and inhumane (NZ, Christchurch "Press", 4/3/95). The wide support for the de-emphasis of the use of imprisonment, in association with humanitarian and civil libertarian movements, has been instrumental in the extensive endorsement that the "least restrictive option" should be utilised whenever possible and that imprisonment should be

imposed only as a last resort. The primary aim of this humanitarian based approach is to minimise the denial of offenders rights, especially basic human rights, while still ensuring that penal sanctions comply with natural justice principles and the broader values of society. Under this approach it has been recommended that offenders are only deprived of their liberty when this is essential for public safety and that prison numbers are reduced to protect prisoners' rights and also to reduce expenditure in this area. However, notwithstanding the principle of last resort, imprisonment still functions as the backbone of the penal system in most western nations (van Zyl Smit & Dünkel, 1991). As previously stated, incapacitation is essential for public safety demands which necessitates imprisonment as there is currently no humane alternative. Given the growing pressure for better public safety levels, there is serious concern regarding the practical power the "last resort" policy has in actively reducing the penal population. The fact is that this de-emphasis on the use of incarceration has not significantly reduced penal populations. On the contrary, in spite of such efforts, prison numbers are found to be increasing in several western countries rather than on the decrease (van Zyl Smit & Dünkel, 1991).

Increasing Crime. The primary problem found across most western countries is that there has been a progressive increase in crime, especially that of violent crime, over approximately the last decade. In NZ, for example, while the national crime rate has fluctuated, the level of violent crime has persistently increased. NZ data shows that there has been a 41% increase in violent crime between 1982 and 1992 (NZ Department of Justice, 1993). Manifestly, this has

heightened the negative attitude toward offenders and has added to the public level of dissatisfaction with the CJS. This is exemplified by the degree of attention this issue has been given by the media (NZ, Christchurch "Press", 5/7/94). In the US there is substantial public support for the current crime bill that, amongst other changes, proposes a federal law change titled "three strikes and you're out", whereby offenders can be imprisoned indefinitely if they commit three felonies in succession (NZ Christchurch "Press", 26/8/94; 27/8/94). The public dissatisfaction with the contemporary climate in this country is comparable. For example, solicitations have been made by certain social factions for such changes as; the reinstatement of the death-penalty, amendments in legislation so that a life sentence will constitute life imprisonment and that degrees of murder become available under NZ homicide laws (NZ, Christchurch "Press", 17/2/94; 27/4/94; 5/7/94; 4/3/94). Given that violent crime appears to be the prevalent problem, it is not surprising that there is growing public pressure for an increase in the use of imprisonment. While the principle of last resort is still widely embodied within penal policy, evidently there are certain circumstances where non-custodial sanctions are not applicable.

In response to the growth in public pressure for reform to provide better public safety levels, the trend across countries has been to impose more severe penalties for certain serious offences. In NZ, this strategy has been employed as is evidenced by the Criminal Justice Act Amendments 1993, which involves such changes as; an increase in the maximum sentence available for sexual violation and an increase in the discretionary power of the courts, whereby longer minimum prison terms are available for certain serious offences.

These changes will clearly influence the use of imprisonment and penal populations. The current lack of public safety and the degree of public pressure for an increase in the utilisation of imprisonment is a matter which the courts are obliged to consider seriously. In line with other western countries, not only are these changes in NZ law likely to increase the number of convicted offenders sentenced to prison but it is also likely to increase the average length of stay (Jemelka, Rahman & Trupin, 1993; Severson, 1992).

Overcrowding. The matter of overcrowding, which has historically raised humanitarian concern due to its association with the inhumane treatment of prisoners, is still a problematic issue (Hilkey, 1988; NZ Department of Justice, 1988; Palermo et al, 1991). Across countries, including NZ, the trend over time has been to direct attention towards establishing non-custodial sanctions and substantiating parole options to elevate prison numbers. However, in light of the current social attitude towards offenders, it is unlikely that prison populations are going to be readily reduced. In the US, penal populations have progressively increased over the last decade or so (Jemelka et al, 1993; Severson, 1992; Steadman et al, 1989). In New York, for example, the population of the state prison has more than doubled, where the population rose from 19 352 in 1977 to 40 842 in 1987 (Greene, 1988). In fact, if similar incarceration rates continue, it is predicted that over two million people will be detained in some type of penal institution by 1995 (Severson, 1992). While penal populations are not as large in this country, in relation to the national population, prison numbers are comparable to that found in the US. Department of Justice data shows that there has been a progressive increase in prison numbers over the past decade in NZ. If

the current rate continues in this country, the national prison population will be around 6 000 by 1996, which is more than a 30% increase on current muster levels (NZ Department of Justice, 1993).

In light of the current rate of imprisonment and these projection rates, there has been renewed concern regarding the problem of overcrowding in prisons. In most countries the building of additional penal institutions as a solution to overcrowding is generally opposed. In the US, while further institutions are under construction, the rate of construction is unlikely to have a significant impact on overcrowding (Jemelka et al, 1993; Steadman et al, 1989). There are plans to build additional prison cells and private prisons in this country as a last resort effort to ameliorate the problem of overcrowding. While such initiatives have received opposition these plans are in progress (NZ Christchurch "Press", 4/1/94). Nevertheless, the most common and favoured response to this issue has been to look for further non-custodial and parole initiatives. In NZ, for example, certain offenders are now eligible for parole after serving one third of their sentence due to 1993 amendments to the Criminal Justice Act 1985. This is clearly aimed at reducing prison numbers, however, parole changes with similar aims, which were introduced under the enactment of the Criminal Justice Act 1985, only produced a temporary reduction in this area (NZ Department of Justice, 1988).

The Effect of the Prison Environment. While further attempts are being made to reduce prison numbers, it is unlikely that such efforts will effectively address the problem of overcrowding in penal populations in the long-term, due to the current social climate. Overcrowding in prisons presents; considerable management

problems, increases the risk of human rights infringements, and increases the likelihood that inmates will endure mental health problems (Axelson & Wahl, 1992; Hilkey, 1988). This brings to question the feasibility of providing comprehensive humane containment under such conditions. It also raises serious concern regarding the general well-being of prisoners and the protection of such persons' rights. The one area that has received heightened attention is the provision of health care, especially MHS. As previously mentioned, humane containment is viewed as an essential "natural justice" provision. This is because it has been well established that the conditions of confinement can have a negative impact on the well-being of inmates (NZ Penal Policy Review Committee, 1982; NZ Department of Justice, 1988; Ostfeld, Kasl, D'Atri, & Fitzgerald, 1987; Treverton-Jones, 1989; van Zyl Smit & Dünkel, 1991). There is reasonable agreement within the literature that the nature of the prison environment can negatively influence prisoners' mental health (Hodgins, 1995; Snow and Briar, 1990). Wormith, Teller and Gendreau (1988) found, for example, that anxiety levels were relatively high for all inmates in their assessment in a Canadian detention centre. Reali and Shapland (1986) reported that in several countries neurosis has been found to worsened during incarceration. Overcrowding in prison is considered one of the major contributing factors in the decompensation of vulnerable individual in custody. Dvoskin and Steadman (1989), for example, have reported that overcrowding in prisons has been linked with increases in suicide rates. Hilkey (1988) asserts that this is due to the lack of personal space that results from overcrowding which tends to decrease inmates' perceived level of safety, predisposing vulnerable inmates to experience psychological and emotional problems.

Across countries, the apparent inability of policy reform to reduce penal populations and eliminate overcrowding, has pre-empted further investigations into the prison system. In NZ, for example, there have been several government inquiries into the management of penal institutions in the last decade or so, to ascertain prisoners' vulnerability under current conditions to human rights infringements, especially regarding the provision of MHS (NZ Department of Justice, 1988; 1989; NZ Ministry of Health, 1988). This focus re-direction has made it clear that the management of custodial offenders has been neglected for some time due to the emphasis placed on the deployment of non-custodial sanctions. In this country, for example, the penal policies endorsed under the authority of Barnett in the 1950's stand out as the most significant changes made for the welfare of custodial offenders (NZ Department of Justice, 1988). In accord with the general social trend found across countries, the incorporation of internationally set standards of conduct into national and regional law has expediently increased over the last few decades for the protection of prisoners' rights (Bayefsky, 1992; van Zyl Smit & Dünkel, 1991). Clearly, this measure is aimed at addressing the issue of the effect of overcrowding and ensuring prisoners' human rights are protected.

Closing Comment. While this growing use of imprisonment as a penalty appears to negate the last resort policy and contravene the primary measures of equity, it has in fact been legitimised. First, the increase in imprisonment mainly relates to the length of stay for serious offenders/offence, which falls within the legal framework of last resort. Secondly, as discussed in the previous section, the social attitude towards a penalty largely dictates whether or not it is

deemed an acceptable method of intervention. Clearly, the issue of public safety and incapacitation appear to be viewed as more important than the cost and the effectiveness of this form of punishment. The third and most pertinent factor that legitimises the current use of imprisonment is the establishment of custodial offenders' rights. The incorporation of international standards of treatment of prisoners into national and regional law means that inmates have legal protection from human rights infringements. This means that the humane element of proportionality is also addressed as prisoners are legally entitled to be humanely contained.

1.3.2. PRISONERS' RIGHTS TO MHT: THE LEGAL FRAMEWORK.

Given that the problem of overcrowding is not likely to diminish in the near future, prisoners' right to MHT is clearly an important contemporary issue. In the present discussion the primary rights in question are fundamental or human rights rather than those that directly relate to citizenship. Under NZ penal policy, in accord with other western nations and in line with international standards, it is held that a term of imprisonment comprises the sanctioned penalty in and of itself (Barbara Hudson, 1987; NZ Penal Policy Review Committee, 1982; NZ Department of Justice, 1988; Treverton-Jones, 1989). In other words, the punishment imposed constitutes the loss of liberty and the respective forfeiture of rights, which means that any deprivation of rights that deviates from the denial of liberty is unconstitutional.

Humane Containment. As highlighted in section 1.2., the protection of offenders' basic human rights has long been an issue of humanitarian concern. Under international human rights principles, it is held that a prisoner's loss of immediate liberty does not constitute the loss of

human dignity (Bayefsky, 1992). In accordance with such standards, under section 23 sub-section 5 of the New Zealand Bill of Rights, 1990, it is stipulated that "...Everyone deprived of liberty shall be treated with humanity and with respect for the dignity of the person. ..". This certified right verifies that the deprivation of custodial offenders' basic human rights is abhorred and deemed unconstitutional in NZ society. This means that in this country, in line with other western countries, the state has the responsibility to humanely contain prisoners. In other words the state has the moral and legal obligation to provide essential resources for the protection of custodial offenders' fundamental humanity. What constitutes essential resources for the provision of humane containment are outlined in the United Nations Standard Minimum Rules for the Treatment of Prisoners (1955). In simple terms, humane containment covers the provision of adequate resources such as; sanitary living conditions, essential nutrition, exercise, and health care, for the protection of inmates' general well-being (Bayefsky, 1992; Cohen, 1993). Manifestly, the negation of prisoners' basic human rights is deemed to supersede the denial of rights integral to liberty and thus the punishment imposed.

Right to MHT. The provision of MHT falls under the state's responsibility to provide inmates with access to adequate health care. The provision of medical services for custodial offenders is deemed essential under humane containment principles on the grounds that it would be cruel and inhumane to deny an inmate with ill-health access to necessary health care due to his/her custodial status. It is well documented across countries that, for whatever reason, there is a significant proportion of prisoners in need of MHT and it is

commonly acknowledged that the rationale for the provision of health care equally applies for the provision of MHS (NZ Penal Policy Review Committee, 1982; Wardlaw, 1983). While the presumption still persists that MDO are generally "weeded-out" of the CJS prior to sentencing, it is largely erroneous, as the majority of clinically MDO are deemed legally fit to plead and legally sane. In other words, offenders can and do enter prison with a pre-existing mental disorder (Freeman & Roesch, 1989; Prins, 1993). Moreover, as highlighted previously, the nature of the prison environment and the act of incarceration are considered to have a detrimental impact on inmates' general mental health (Axelson & Wahl, 1992; Bartol, 1991; Hodgins, 1995; Reali & Shapland, 1986; Snow & Briar, 1990). Evidently, as MDO do reside in custody and, because custodial offenders are also at risk of mental deterioration as a result of incarceration, MHS are an essential provision.

Across countries, in correspondence with international standards, it is widely sanctioned under the relevant penal legislation that the provision of MHS is an essential requirement in prisons (van Zyl Smit & Dünkel, 1991). The provision of MHS is commonly established as essential under the premise of humane containment. Clearly, the deprivation of prisoners' basic human rights is not only deemed cruel and inhumane, but is also sanctioned under penal policy as disproportionate to the said punishment. In line with international human rights standards, it is stipulated under the New Zealand Bill of Rights, 1990, section 9, that "...Everyone has the right not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment. ...", which is comparable to constitutional declarations in other western countries, such as the

Eighth Amendment in the United States (Cohen, 1993). It is via this fundamental right as a person, that prisoners have the constitutional right to MHT.

Closing Comment. Clearly then, because persons with custodial status are solely dependent on the state, via prison authorities, the state is duty bound to provide certain resources. This means that while certain rights are lost due to the denial of liberty, some rights are in fact accrued through the act of confinement, rights that are not otherwise affirmed for persons outside this legal framework (Cohen, 1993; NZ Ministry of Health, 1984). The right to MHT is such an additional entitlement that is contingent upon confinement, and is verifiably in this country via section 9 of the NZ Bill of Rights.

1.3.3. SECTION SUMMARY.

While the premise of the least restrictive option is still widely endorsed under penal policy across several western nations, it is evident that this objective has not produced a permanent decline in the use of imprisonment. Notwithstanding the support for the multiple arguments against the use of imprisonment, the current social trend of increasing violent crime has resulted in penal reform that has increased the likelihood of imprisonment for serious offenders and it is apparent that this change in policy is likely to exacerbate the problem of overcrowding in penal institutions. This has finally drawn attention back to the management of penal institutions and the well-being of custodial offenders. This increase in the use of imprisonment is largely justified on the grounds that prisoners' human rights are legally protected. The primary question being raised, however, is whether or not prisoners' basic human

rights, especially such persons' rights to MHS, are adequately protected.

1.4. THE "GAP" BETWEEN PRISONERS' PAPER AND PRACTICAL RIGHTS.

As described in the preceding section, in the past few decades international human rights principles have been readily assimilated into national and regional law. In NZ, in line with other western countries, certain international documents depicting prisoners' basic rights have been ratified[6], which signifies that persons with prisoner status are **not** deemed to have forfeited all rights. Nevertheless, there is still some debate concerning what rights prisoners should be afforded and there is also substantial confusion regarding what constitutes prisoners' rights per se, due to the nature of the legal framework. This has brought into question the degree to which international standards have been established within the law and, more importantly, whether such standards are being practically fulfilled (Bayefsky, 1992; van Zyl Smit & Dünkel, 1991). Given the current problem of overcrowding, prisoners' rights to MHS has become a reasonably topical contemporary issue. It is evident that in NZ, in accord with other western countries, prisoners are deemed to have certain rights and that the provision of MHS is one such entitlement. The case in point is that, regardless of the varying arguments concerning what rights should be given to prisoners, the state has the legal obligation to practically fulfil the rights that **are** afforded. The area of concern in this discussion is prisoners' legal entitlement to MHT and the practical fulfilment of this right. What follows is an

[6]The United Nations Standard Minimum Rules for the Treatment of Prisoners (1955) and the Declaration on the Protection of all Persons from Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1975).

examination of the problems involved in the legal framework in question and the practical implications.

1.4.1. THE EQUIVOCALITY OF PRISONERS' RIGHTS TO MHT.

As highlighted in section 1.3.2, prisoners arguably have the constitutional right to MHT under the premise of humane containment. Nevertheless, this particular matter has not escaped the "rights versus privileges" debate. While it is widely acknowledged that MHS are an essential requirement for the provision of humane containment, it is not as readily agreed that prisoners have the "right" to such services. This lack of congruity is primarily due to the nature of this type of right and the vagueness of the legal framework in question.

Positive Rights. A beneficial classification of rights, presented by Monahan (1982), holds that there are two basic types of rights. In simple terms, there are negative rights which relate to being free from control, especially by that of the state, and then there are positive rights which constitute entitlements to social resources. Monahan asserts that the focus has been placed so strongly on establishing negative rights that the state's responsibility to provide social resources to protect positive rights has largely been ignored (Keilitz and Roesch,1992). Monahan argues that as a result, positive rights or entitlements are not adequately defined within the law, which subsequently limits the legal protection available for this type of right. There are various social resources such as; health care, education and welfare provisions, that are viewed as entitlements in several western nations. It is apparent that the protection of persons' human rights is integral to the certification of positive rights and that prisoners' right to MHS falls within this category.

Across most western countries, however, the state's commitment to fulfil its legal obligation to provide social resources is largely established under social policy. What makes this problematic is that social policy functions as the weakest form of legal protection. Social policy is not only subject to recurrent change in accord with shifts in the socio-political climate but it is also the most difficult form of legislation to police, as policy generally has an imprecise quality yielding a low level of accountability. It is in light of this volatility of social policy that Keilitz and Roesch (1992) have taken Monahan's argument a step further in the claim that the definitional ambiguity of entitlements has created an inherent gap between "paper" and "practical" rights.

The Imprecision of the Legal Framework. The volatile nature of social policy clearly predisposes all citizens to human rights infringements, however, the nature of the legal framework that underpins prisoners' rights exacerbates such persons' vulnerability to infringements. Incarceration is clearly restrictive, which necessitates that the legal emphasis is placed on what is **not** permissible for prisoners rather than what is allowed (NZ Penal Policy Review Committee, 1982; NZ Department of Justice, 1988). In fact, because inmates are fundamentally dependent on prison authorities for humane containment, the primary consideration is to establish the responsibilities of penal staff. Manifestly, what are most commonly stipulated under penal legislation across countries, are the duties of the prison authorities rather than prisoners' rights per se (van Zyl Smit & Dünkel, 1991). Moreover, while the duties of the prison authorities sanctioned under the germane legislation is widely found across countries to be in line with internationally set

standards[7], the legislation in question primarily specifies the minimum standard of conduct required by prison authorities. (NZ Department of Justice, 1988; 1989; Treverton-Jones, 1989).

As is comparable to other western countries, the legislation pertinent to the provision of MHS within the NZ context, primarily defines the minimum obligation of prison authorities and is inherently vague. The most relevant legislation in this country closely follows principles 22 through to 26 of the United Nations Standard Minimum Rules for the Treatment of Prisoners (1955), which deal specifically with the provision of medical services. Under section 36 of the Penal Institutions Regulations, 1961, for example, it is stipulated that "... Any officer who notices that any inmate does not appear to be in good health, although he may not complain, or that his state of mind appears to be of notice or care, shall inform the Superintendent in order that the opinion and instructions of the medical officer may be obtained...". While this shows that the protection of prisoners' mental health is viewed as a duty of prison authorities, this regulation does not specify prisoners' entitlement in this regard. Subsequently, it is not surprising that there is a general lack of clarity regarding what constitutes a "right" or a "privilege" for prisoners and that there is also reasonable confusion for both penal staff and inmates concerning prisoners' entitlement to MHT (NZ Penal Policy Review Committee, 1982; NZ Department of Justice, 1988; Treverton-Jones, 1989).

Clearly, the pertinent legislation only stipulates the minimum standards of treatment. As indicated above, the provisions required

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[7] most notably in accordance with the United Nations Standard Minimum Rules for the Treatment of Prisoners (1955).

for the humane containment of prisoners should be stipulated under policy. Across most western countries, the commonly held policy objective is to *surpass* minimum standards and provide a comprehensive MHS system, for the humane containment and rehabilitation of inmates (NZ Penal Policy Review Committee, 1982). Commonly found generic policy statements exemplify this aim. For example, Johnson and Hoover (1988) have reported that the mission statement of the Federal Bureau of Prison in the United States is to provide "MHS that are humane, effective and comprehensive." (pp. 674). This is congruent with the policy approach in NZ. In this country the primary aim underpinning the provision of MHS is to provide a "humane and therapeutic" prison environment for the well-being and reintegration of inmates (NZ Department of Justice, 1988). This policy objective is clearly aimed at providing adequate services for the protection of MDP' entitlement to MHT. However, these generic policy goals do not guarantee service provision or specify the types of services required. In England, Canada and various jurisdictions in America, as a result of the obscurity of the legal framework and in response to the absence of clear policy standards, various codes of treatment and standards of mental health care have been set by departments of corrections and/or mental health agencies (Steadman, McCarty & Morrissey, 1989). The issue of implementing a generic code of treatment for prisoners has also been addressed in a number of NZ inquiries and recommendations have been proposed (NZ Department of Justice, 1988; 1989; NZ Ministry of Health, 1989). Nevertheless, while improvements have been instigated as a result of certain policy reform in some jurisdictions in the United States (US), this strategy has largely accentuated the diversity in the standards found amongst penal institutions (Steadman et al, 1989). Moreover, it

has also been found that such endeavours pose similar implementation difficulties as generic policy guidelines.

Disparity between Prisons. It is apparent that the nature of this legal framework allows for considerable deviation in the provision of MHS. Although the employment of MHS is commonly viewed as a necessity for the provision of humane containment, the nature of the services required is not universally agreed upon (van Zyl Smit & Dünkel, 1991). The provision of MHS and the fulfilment of this legal requirement is largely governed by policy, which essentially functions as a guideline rather than a comprehensive code of treatment for prisoners. As a result, it has been found across countries, that the management of penal institutions can vary widely between regions and across jurisdictions. For example, McBride (1980) points out that in NZ, the fulfilment of prisoners' rights largely depends on the personality of the superintendent and the prison officers rather than the law per se. Manifestly, the fulfilment of prisoners' entitlement to MHT is likely to be influenced by the internal management of the penal institutions, which means that there is likely to be disparity amongst penal institutions, both across jurisdictions and countries, in the availability of MHS. Prins (1993) asserts that an important factor involved in the provision of MHS for inmates is the social attitude towards mental health issues. Warner (1989) found, for example, that the general attitude towards mentally disordered persons within the community was the most significant factor in the provision of MHS for inmates in a Colorado jail (Steadman, et al, 1989). Prins (1993) also indicates that the availability of MHS in the community is what commonly determines the level of social resources made available for inmates. This view

is supported by findings such as those ascertained by Miller (1992). Miller's research involved the comparison of court procedures in three American states and a positive relationship was found between the funding level for MHS in the community and offenders' access to such services.

While this will be discussed more fully in subsequent sections, it is apparent that, across several western countries, there has been a notable reduction in the general expenditure on social resources, especially in the mental health sector, which is likely to have an influence on inmates' access to MHS. This is evidenced by the fact that the limitation of fiscal resources within corrections and the reduction of community based MHS has been cited under policy recommendations across countries, as the primary boundary for defining treatment availability (NZ Department of Justice, 1988; Rogers & Webster, 1989). As indicated in section 1.3.2., however, the right to treatment relates specifically to prisoners' custodial status. This means that, unlike the average citizen, the lower level of mental health resources currently found within the community, is not technically relevant to the issue of prisoners' entitlement to MHT. Although resource availability is evidently a necessary consideration, such factors should not be used as a justification for human rights infringements (Cohen, 1993; Steadman, McCarty, & Morrissey, 1989).

Court Action. Traditionally the courts have not directly dealt with the issue of prisoners' constitutional rights (NZ Department of Justice, 1988; Smith, 1993; Steadman et al, 1989; Treverton-Jones, 1989). However, the general pressure over the last few decades for a legalistic model of rights has lead to court intervention in the US in the effort to clarify the issue of prisoners' right to MHT. There are

two such cases that are worthy of mention. In the case of Estelle v. Gamble (1976), it was ruled by the United States Supreme Court that prisoners **do** have a constitutional right to treatment. It was also substantiated in this case that the "deliberate indifference" of prison authorities towards prisoners' "serious needs" contravenes the Eighth Amendment (Cohen, 1993; Dvoskin & Steadman, 1989; Severson, 1992). More pertinently, it was established in Bowring v. Godwin (1977) that "...psychiatric and psychological services were held to be as "necessary" as other medical services. ..." (pp. 203; Dvoskin & Steadman, 1989). It is via these two cases that the provision of medical care for prisoners, including MHT, has been verified by the courts as a constitutional right in the US.

In NZ, however, no such court action has been undertaken. This means that while prisoners have the constitutional right to MHT, as is verifiable via section 9 of the NZ Bill of Rights, this entitlement has not been substantiated by the courts. It is presumed by the authors of a NZ governmental inquiry (1988), that if such a case is brought to court in this country, it is likely that NZ would adopt the approach taken by the English judiciary. The few court cases that have addressed prisoners' constitutional rights in England have been dismissed on the grounds that the given complaints had no firm basis for legal recourse (NZ Department of Justice, 1988; Treverton-Jones, 1989). This indicates that the traditional "hands-off" approach taken by the courts regarding the constitutional rights of prisoners, still prevails in some countries, including NZ. This raises some concern regarding the legal status of prisoners' constitutional rights to MHT across countries. Although prisoners are entitled to MHT in this

country, the absence of confirmation through the courts brings to question the enforceability of this right.

Closing Comment. Notwithstanding the significance of court action, it is evident that there are some limitations at the practical level. Due to the nature of the legal framework in question, the *due process* issue for the courts is the provision of the minimum standards of treatment, rather than the provision of comprehensive MHS per se (Cohen, 1993; Dvoskin & Steadman, 1989; NZ Penal Policy Review Committee, 1982; NZ Department of Justice, 1988; Treverton-Jones, 1989; Severson, 1992). This means that the courts are unlikely to address any requirements beyond the minimum standards, yet in NZ, in line with other western countries, the policy objective is to supersede the minimum standards specified within this legal framework. Therefore, while court action is an efficacious avenue to affirm this constitutional right, it is unlikely to offer a satisfactory practical solution to the provision of MHS. As has been recommended in NZ, what is ultimately required to reduce this current level of ambiguity, for the mutual benefit of penal staff and inmates, are amendments to the pertinent legislation (NZ Penal Policy Review Committee, 1982; NZ Department of Justice, 1988).

1.4.2. THE AMBIGUITY OF THE PSYCHO-LEGAL CONTEXT.

As already highlighted, it has been verified in several countries that there is a substantial demand for MHS across penal populations. While it is evident that many prisoners may benefit from MHT, this does not mean that all prisoners have the constitutional right to MHT. What determines prisoners' legal entitlement to MHT is the psycho-legal context in question. As previously mentioned, prisoners' constitutional right to MHT falls within the confines of the state's

legal obligation to humanely contain custodial offenders. In other words, the psycho-legal context is the relationship between prisoners' mental health status and the provision of humane containment. What is problematic, however, is that the boundaries depicting this psycho-legal context are very loosely defined, which has largely blurred prisoners' eligibility to such services.

Humane Containment and Rehabilitation. The first problem is the apparent ambiguity regarding the rationale underlying prisoners' entitlement to MHT. As highlighted in the former section, the provision of MHS under the premise of humane containment, is rationalised on two divergent grounds. To recap, the first rationale is that it would be cruel and inhumane to deny MDO essential treatment due to their custodial status. The second and more pertinent justification is that incarceration is considered likely to have a negative influence on prisoners' mental health status, which is an incidental consequence of imprisonment. In other words, the state is deemed to have the duty to provide prisoners with access to MHS to commensurate the negative impact imprisonment may have, including the lack of independent access to essential treatment. Clearly, prisoners' constitutional right to MHT is integral to this duty of the state. The critical point here is that the constitutional right to MHT comes under the state's legal obligation to protect prisoners' human rights. However, as referred to in section 1.2., there are certain psychological disturbances, maladaptive problems and diagnosable mental disorders, that have been associated with offending behaviour. Subsequently, the use of a wide range of MHS for rehabilitative measures is an endorsed practice in several western countries (Bartol, 1991; Shah,1993). This, however, is one factor that has

clouded the definitional boundaries in question. Clearly, the state has an obligation to the community and to offenders to provide rehabilitative MHT, nevertheless, the rehabilitative goal of MHT does not constitute the rationale for the provision of treatment under prisoners' constitutional entitlement (Cohen, 1993). Although, MHT provided under the premise of humane containment may have rehabilitative benefits, this is not the rationale for supplying this service. Nevertheless, across countries and jurisdictions, the dual purpose of rehabilitation and the protection of prisoners' human rights, is commonly combined as a policy objective for the provision of MHS. Manifestly, this obscures the independent nature of the rationale underlying each function of MHT. While prisoners have the constitutional entitlement to MHT for the protection of human rights, there is no such legal entitlement to rehabilitative treatment (NZ, Department of Justice, 1988; Steadman et al., 1989; Severson, 1992). The shadowing of this important distinction between prisoners' entitlements to treatment and the provision of services under policy has added further confusion regarding prisoners' entitlements to MHS.

Mental Health Status. The second problem in question is the relevance of offenders' mental health status within the given legal context. There are multiple psycho-legal contexts found throughout the CJP, such as; the insanity plea and the plea of unfit to plead, all of which come with certain definitional ambiguity (Greenberg & Bailey, 1994; Shah, 1989; 1993). However, it appears that the psycho-legal context in question is fraught with imprecision. At the community level a wide range of MHS is provided for a broad range of psychological disturbances, emotional and maladaptive problems that do not meet with the

diagnostic criteria (in nature or severity) in accordance with the clinical judgement of a mental disorder (Bartol, 1991; Shah, 1993). Clearly the state's legal obligation does not involve the provision of services for the treatment of all prisoners' emotional or psychological disturbances. The case of Youngberg v. Romeo (1982), again in the US, established that the criteria for prisoners' eligibility to MHS is the presence of a clinically diagnosed mental disorder (Severson, 1992). This ruling is in line with policy guidelines found across countries, including NZ, however, this criteria is still problematic. Although this standard provides an important definitional boundary for prisoners' entitlements to MHS, there are multiple terms of reference for a mental disorder, within both the legal and mental health frame of reference. In the mental health field, the most widely accepted definitional criteria for mental disorders are stipulated in the DSM III-R[8] and in the ICD-9[9]. The primary function of disorder classifications in the DSM III-R, for example, is to discern the etiology, prognosis, and treatment options for specific disorder types, especially with respect to medication. As it is clearly stated in the DSM III-R, this manual is for clinical and research purposes, and that what constitutes a mental disorder within this framework may not be wholly relevant to legal judgements (Shah, 1989).

In simple terms, the fundamental purpose of any legal definition of a mental disorder is to uphold the principles of natural justice (Prins, 1980; Shah, 1989; 1993). Therefore, while the clinical term of reference for a mental disorder is essential within the legal context, the presence of a disorder may not be viewed

[8] The revised third edition of the Diagnostic and Statistical Manual of Mental Disorders

[9] The International Classification of Diseases, the ninth revision

relevant for the purpose of the legal inquiry. For example, to comply with the premise of natural justice during the court proceedings, mental health expertise may be required, where appropriate, to help the court determine the defendant's capacity to stand trial and/or the degree of criminal responsibility. However, for a defendant to be deemed unfit to plead (or incompetent to stand trial) or legally insane, a clinical diagnosis of a disorder is required, the disorder is commonly required to meet with the commitment criteria stipulated under mental health legislation and it must also be deemed applicable within the context of the court. Consequently, an alleged offender may receive a clinical diagnosis of a mental disorder that is judged by the court to bear no relevance within the context of the criminal proceedings (Aviram, 1990; Bartholomew, 1981; Bartol, 1991; Freeman & Roesch, 1989; Greenberg & Bailey, 1994; Jackson, 1986; Kopelman, 1990; Shah, 1989, 1993; Sherlock, 1985). Likewise, while the primary criteria defining prisoners' right to MHT is a clinically diagnosable mental disorder, the said disorder may not be deemed relevant within the legal bounds of this entitlement.

Eligibility: Disorder Type and Severity. The nature of the mental disorder clearly influences prisoners' entitlement to MHT. However, the question is raised as to what type of disorder determines prisoners' eligibility to MHT within the legal context of humane containment. Unfortunately, this is a problematic question because it is apparent that what MHS are required within the legal framework of humane containment is still under debate. For example, psychosis, personality disorders, substance use disorder, mental retardation and mentally disordered sex offenders (MDSO) have widely been the

primary conditions of concern across western countries (Prins, 1993). Nevertheless, there is much debate regarding whether all these conditions fall within the parameters of prisoners' entitlement to MHS. The incidence of antisocial personality disorder, substance use disorder and MDSO are likely to be widespread within penal populations due to the inclusion of offending behaviour in the diagnostic criteria (Prins, 1993). Although there may be certain circumstances where these disturbances fall within the boundaries of humane containment, such as drug-withdrawal, the provision of MHS for the majority of these conditions arguably comes under the bounds of rehabilitation not humane containment.

As previously mentioned, it is well documented within the literature that inmates are considerably vulnerable to further impairment due to incarceration (Bartol, 1991; Prins, 1993). However, the focus within the literature has been the decompensation of psychotic inmates. This emphasis is principally legitimised by the option, commonly available across countries, to transfer MDP to a psychiatric hospital under mental health legislation. In NZ, for example, a prisoner may be transferred to a psychiatric hospital, as a special patient, under section 45 or 46 of the Mental Health (Compulsory Assessment and Treatment) Act (MHA) 1992. To be eligible for transfer a prisoner's condition must meet with the legal definition of a mental disorder under this act to justify commitment. Under section 2, sub-section (1), of the NZ MHA 1992, it is stipulated that for the purposes of this Act the term "... "mental disorder", in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a

degree that it- (a) Poses a serious danger to the health or safety of that person or of others; or (b) Seriously diminishes the capacity of that person to take care of himself or herself;- ...". It is apparent that inmates suffering from fluid psychotic symptoms are the most likely to fall within this definition of a mental disorder.

While the provision of MHS for psychotic inmates is not disputed as an essential requirement, this does not negate the constitutional importance of the provision of MHS for less salient disorders under the premise of humane containment. Bayefsky (1992) points out that, in accordance with international standards, ..." [t]he term "cruel, inhumane or degrading treatment or punishment" should be interpreted so as to extend the widest possible protection against abuses, whether physical or mental, including the holding of a detained or imprisoned person in conditions which deprive him..." (pp. 398, Bayefsky, 1992). Given the general nature of the prison environment it is not surprising that signs of depression and anxiety are found amongst inmates (Bartol, 1991; Prins, 1993). As previously mentioned, Wormith et al (1988) found that all inmates in their study were found to have relatively high anxiety levels. Moreover, the problem of prison suicide, which is common across countries, indicates that a proportion of inmates experience symptoms of depression. While suicide is not always indicative of clinical depression, it is often considered a factor (Prins, 1993). Clearly, mood and anxiety related disorders can be directly associated with the act of incarceration, which signifies that the provision of MHS for these types of disorders falls under the requirements of humane containment. Unfortunately however, there has been little attention paid to the entitlements of prisoners with disorders such as these.

The emphasis placed on the definition of a mental disorder under mental health legislation is likely to be the major reason inmates with less pervasive disorders are largely overlooked. Not only is the nature of the disorder an important factor in the transfer of inmates to hospital but so is the severity of the disorder in question. While inmates with a severe mood disorder may be viewed as eligible for a transfer, for example, it is unlikely that a severe anxiety related disorder would be deemed applicable. This significance placed on the issue of disorder severity is commonly found under policy recommendations. In the US, for example, the court ruling that a "serious need" is required to be present, has reinforced this recommendation. However, this court ruling and the option to transfer inmates under mental health legalisation constitutes a minimum standard, yet the common policy objective is to supersede these minimum requirements. Under NZ penal policy, for example, the objective is to provide the resources necessary, so that the well-being of inmates is no worse upon release than that found at admission (NZ Penal Policy Review Committee, 1982; NZ Department of Justice, 1981; 1988; 1989). Clearly then, it is arguable that prisoners' suffering from less salient and less severe disorders, such as mood and anxiety disorders, are eligible for MHT under humane containment in this country.

Closing Comment. It is pointed out by Ogloff and his colleagues, that a reasonable number of prisoners are not likely to want MHT even if it is considered appropriate (Ogloff, Roesch, & Hart, 1993). In other words, the right to treatment does not mean that prisoners have to undertake the treatment offered (NZ Ministry of Health, 1984). This has raised the issue of prisoners' right to refuse treatment and is a

matter that has received a considerable degree of attention by civil libertarians and researchers alike (Cohen, 1993; NZ Ministry of Health, 1987; Prins, 1980). While the validation of prisoners' right to refuse treatment is appropriate, this matter is clearly secondary to the issue of prisoners' right to receive MHT and is largely outside the framework of the current discussion. As Cohen (1993) has stated, the right to refuse treatment is generally only an issue for prisoners' who are eligible for a hospital transfer because such persons are likely to be subject to compulsory treatment, which constitutes the minority of MDP. The pertinent issue at hand is prisoners' eligibility to MHT within the legal framework of prisoners' right to such services.

1.4.3. SECTION SUMMARY.

While prisoners' constitutional right to MHS has been mandated by the courts in the US, no such court action has been undertaken in this country. This heightens the vulnerability of inmates in NZ to such human rights' infringements. Nevertheless, while court action has set an important precedence in the US, this has not had a great impact on the law governing the provision of MHS for inmates. The ambiguity of the relevant legal framework in the US is still comparable to that of other western nations, including NZ. It is evident that across countries, the practical fulfilment of this legal entitlement is primarily considered to be a policy matter (NZ Department of Justice, 1988; Severson, 1992). The general vagueness of social policy, and the inherent problems involved in implementing policy objectives, clearly bring to question whether an adequate level of MHS are provided. Manifestly, the central issue of concern is that the **right** to MHT appears to be substantially unenforceable for those whom this

legal provision is intended (Cohen, 1993; Hodgins, 1995; NZ Department of Justice, 1988; 1989). Across most western countries, while it is acknowledged that MDP have the constitutional right to MHT, it is unclear who is eligible for such services. The fuzzy boundaries defining the legal context of humane containment makes the relevancy of prisoners' mental health status even more obscure than found elsewhere within the CJS. While a certain degree of discretionary power is essential for the protection of offenders' rights, the absence of comprehensive boundaries defining the legal context, heightens prisoners' vulnerability to infringements. The minimum standards of treatment appear to be the most legally binding requirement and therefore the most likely to be fulfilled, which suggests that only prisoners with salient and severe mental disorders are likely to have access to MHS.

1.5. THE PREVALENCE RATE OF MENTALLY DISORDERED PRISONERS.

The first matter that needs to be addressed, to practically respond to the issue of MDP' legal entitlement to MHT, is the demand for MHS within prison populations. It is somewhat difficult to compare prevalence research between countries and across jurisdictions due to such matters as; the legal framework; the definition of a mental disorder, the sample size, and the type of penal populations examined (Bartol, 1991; Hodgins, 1995; Jemelka et al, 1993; Porporino & Motiuk, 1995; Prins, 1993; Roesch, et. al., 1995; Wardlaw, 1985). Nevertheless, prevalence research is essential to ascertain the level of services required and comparisons within and between countries can be utilised to establish if there is a general trend present (Bartol, 1991; Prins, 1993). Therefore what follows is an overview of the available

research on prevalence rates and how this relates to the legal context in question.

1.5.1. THE DEMAND FOR MENTAL HEALTH SERVICES IN PRISONS.

The United States and Canada. As previously mentioned, it has been widely reported across many western countries that there is a substantial demand for MHS within penal populations (Bartol, 1991; Prins, 1993; Wardlaw, 1983). This information has largely been established through surveys and descriptive based assessments. For example, a national survey of state and federal correctional facilities was undertaken in the US in 1983. Pelissier (1988) reports that the survey evidence revealed that "...6% of the inmate population can be classified as mentally ill..." (pp. 703). These results are in line with research undertaken by Dvoskin and Steadman (1989), who surveyed the mental health status of a sample of inmates in the New York prison system (n = 36 144). It was found that 5% of the inmates were "severely psychiatrically disabled". It was also found, however, that an additional 10% were "significantly psychiatrically disabled". This latter finding is congruent with other survey based research conducted in the US and Canada (Hodgins & Côté, 1993; Jemelka, Rahman, & Trupin, 1993; Roesch, Ogloff, & Eaves, 1995; Wardlaw, 1983). Hodgins (1995), for example, reported that studies in Canada indicate that around 5% have a severe disorder and an additional 20% have other disorders. Evidently, in the US and Canada, the incidence of psychiatric problems amongst prison inmates has been found by survey methods to range from 5 to 20 percent, depending on severity.

The United Kingdom and Australia. Survey based information is also available for various countries within the United Kingdom (Bartol, 1991; Côté & Hodgins, 1992; Prins, 1993; Wardlaw, 1983). Prins (1993), in his review of the literature, highlights that the need for MHS in penal institutions within the United Kingdom is comparable to that of the US. Given the available data, Scott (1969) surmised that approximately 15% of inmates in penal custody had a diagnosable psychiatric disorder. This is in line with official data from the NACRO[10] (1987) on prisoner referrals to psychiatrists (Prins, 1993). However, Gunn, Robertson, Dell and Way (1978) concluded from their research in England that 38% of the prisoners studied (n = 629) required psychiatric treatment (Prins, 1993; Wardlaw, 1983). This finding by Gunn et al (1978) is congruent with other research conducted in the United Kingdom and is comparable with research undertaken in Australia (Côté & Hodgins, 1992; Prins, 1993; Wardlaw; 1983; NZ Department of Justice, 1981). For example, Wardlaw (1983), in his review of the literature, examined research by Bluglass (1966), who investigated the rate of mental health problems experienced by 300 inmates in a prison in Perth, Australia. Bluglass found that 46% of the convicted prisoners examined were "psychiatrically abnormal" and required MHS. Therefore while some researchers have reported similar prevalence rates in the United Kingdom and Australia as found in the US and Canada, other estimates suggest that a considerably higher percentage of prison inmates may have psychiatric disturbances.

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[10]National Association for the Care and Resettlement of Offenders.

New Zealand. In NZ, there is very little information available in this regard. Indirect estimates can be ascertained via Justice Department records, in the form of individuals receiving psychological and psychiatric treatment. The 1991 census on inmates, for example, showed that 15.5% of the total prison population were receiving such care at the time of the survey (NZ Department of Justice, 1993). There have also been multiple government inquiries, most notably over the last decade, investigating various aspects of MDO in this country. There is no direct data obtained via such reports, nevertheless, it has been suggested that the demand for MHS in NZ penal institutions is likely to be consistent with that found in other western countries (NZ Department of Justice, 1981; 1984; 1988; NZ Ministry of Health; 1984; 1989).

Closing Comment. This survey based data highlights the importance of providing MHS and shows that there is a call for such provisions in penal institutions. The estimates far outweigh those found in the general population (NZ Department of Justice, 1981; Hodgins, 1995; Hodgins & Côté, 1993; Jemelka, et. al., 1993; Peters & Hills, 1993; Rice & Harris, 1993; Roesch, et al, 1995). However, this type of information offers very little insight into the demand for MHS within legal and practical parameters. The first issue is the reliability of this type of data. Hodgins (1995) and Ogloff, Roesch and Hart (1993) point out that survey based information is likely to underestimate the demand for MHS, which subsequently provides an inaccurate presentation of what services are required. Secondly, while it is clear from the data available that estimates of prisoners who may benefit from MHT ranges from

5% to 46%, the issue at hand is the prevalence rate of prisoners who are entitled to MHT under the legal framework of humane containment. As already discussed, in most western countries, including NZ, the presence of a clinically diagnosed mental disorder functions as the primary criteria for prisoners' entitlement to MHT under humane containment. More specifically, as depicted in the previous section, the primary disorders that fall within this legal framework and are deemed relevant in this research are; psychosis, mood disorders, and anxiety disorders.

1.5.2. PREVALENCE ESTIMATES OF MENTALLY DISORDERED PRISONERS.

Major Mental Disorders. In response to the heightened concern in this area, over the last decade or so, there has been a growth in empirically based research to ascertain a more definitive account of the prevalence rate of mentally disordered persons residing in penal custody. The primary research focus has been the prevalence of inmates who suffer from a major mental disorder (such as schizophrenia, bipolar disorder and major depression) and/or those who are likely to meet the commitment criteria under mental health legislation. Jemelka et al (1993) conducted a review of the research undertaken in America and Canada and found that prevalence estimates ranged from 1.5% to 4.4% for schizophrenia; 0.7% to 3.9% for mania and 3.5% to 11.4% for major depression. These findings are consistent with survey based data, however, Hodgins (1995) affirms in her review of the literature, that when standardised assessments are utilised, prevalence estimates generally exceed those obtained via survey methods. For example, Côté and Hodgins (1992) found in their Canadian study, involving convicted homicide offenders, that 35% of the random sample ($\underline{n}$ =

650) were suffering from a major mental disorder. These findings are consistent with other empirically based data obtained in the US and Canada and are also comparable with prevalence estimates reported in Britain and Scotland (Côté & Hodgins, 1992; Porporino & Motiuk, 1995). In NZ no empirically based research has been undertaken to ascertain the prevalence rate of MDP. Noted in the Mason report (1988) are prevalence estimates obtained through a national census of prison inmates. It was reported by prison staff that approximately 5% (119) of male inmates and 16% (19) of female inmates were considered to be eligible for a transferral to a psychiatric hospital (NZ Ministry of Health, 1988). These survey estimates are consistent with overseas data, showing that the prevalence of prisoners with severe major disorders outweighs that found in the general population. Collectively the above findings indicate that across countries there is a small but significant proportion of the prison population that is likely to suffer from a severe major disorder (Hodgins, 1995; Jemelka et al, 1993; Porporino & Motiuk, 1995). This group of MDP, which appears to constitute around 15% of the prison population when taking the average estimate, is widely viewed as eligible to MHT under the legal framework in question and is clearly entitled to adequate access to the appropriate MHS.

Offence Related Disorders. What is commonly found in prevalence data is estimates of those with offence related disorders. The prevalence of offenders in custody with a personality disorder, most notably anti-social personality disorder (APD), is reportedly high in most penal institutions across countries and jurisdictions (Bartol, 1991; Hodgins, 1995; Hodgins & Côté, 1993; Prins, 1993).

Jemelka et al (1993) found that the prevalence estimates of prisoners with APD ranged between 44.0% to 50.9%, which well exceeds that found in the general population. The difficulty of managing inmates with personality disorders has been addressed in government inquiries in NZ, yet no prevalence information has been presented (NZ Ministry of Health, 1984; 1988; NZ Department of Justice, 1988). Nevertheless, this evidences that inmates with personality disturbances reside in NZ prisons. However, given that the diagnostic criteria for APD includes the display of deviant social behaviour, it is widely assumed that a disproportionate number of inmates will have APD (Prins, 1993).

The prevalence rate of alcohol and/or drug related disturbances has been reported to be as low as 11% and as high as 80% (Prins, 1993). While less attention has been paid to the prevalence rate of sexual deviancy amongst inmates, it also appears to be reasonable common (Prins, 1993). Porporino & Motiuk (1995) found, for example, that 19.8% of the federal inmates assessed in their study had psycho-sexual problems. Again in NZ, while the provision of MHS for alcohol and drug issues and for sexual deviancy has received considerable attention, there is an absence of empirically based research in this area. Given the demand for such services, however, it is apparent that these mental health issues are common amongst inmates in this country (NZ Department of Justice, 1993). Prins (1993) points out that it is not unexpected that persons with these issues will reside in penal custody given the fact that certain sexual behaviour and substance use are defined as criminal and as a mental health problem. As has been discussed in section 1.4.2., some inmates suffering from these

disorders may be viewed as eligible to MHT within the legal framework of humane containment. Nevertheless, in general, these mental health issues fall under the provision of rehabilitative MHS. While it is important to ascertain the demand for rehabilitative MHS, the prevalence rate of these disorder types is clearly not central to the issue of protecting prisoners' entitlement to MHS under humane containment. In fact, the inclusion of these types of disorders could be argued to skew the focus of prevalence research away from the critical issue of humane containment.

Other Disorders. The emphasis placed on severe overt disorders means that it is likely that there is an "unknown" percentage of prisoners' suffering from a diagnosable disorder relevant to the legal context in question (Prins, 1993). For example, while it is apparent that mood related disorders have been flagged within the research as a significant disorder type, the focus has primarily been on these who would be eligible for a transfer to hospital. With the emphasis on severity, however, it is likely that a proportion of inmates' suffering from a mood disorder have been overlooked. This is exemplified by such incidents as prison suicides. It was reported in NZ that 53 prison inmates took their lives while serving a prison term, in the years between 1980 and 1994 (Christchurch Press, 16/05/95). The matter of prison suicide is a commonly found problem across countries. In Britain, for example, it has been reported that prison suicides are three time more likely than that in the general population (Prins, 1993). The suicide rate in US penal institutions has been estimated to be five times that found in the general population (Cox, McCarty, Landsberg & Paravati, 1988). As previously mentioned, while

psychological problems are not the only variables that can contribute to the act of suicide, the problem of suicide in penal custody, indicates that there is likely to be a number of inmates with psychological problem who would benefit from MHT and who are also likely to be entitled to such services. Cox et al (1988) reported, for example, that it was found that 50% of inmates who took their lives in 1982 did have MHT for mental disorders in the past. As highlighted in the preceding section, there is research evidence that indicates anxiety disorders may be common in custodial settings (Porporino & Motiuk, 1995; Prins, 1993; Wormith et al, 1988). Nevertheless, there is an absence of prevalence information on custodial offenders with less salient mental disorders, such as anxiety states. Not only can these types of disorders be extremely debilitating but they also arguably fall within the legal parameters of MDP' entitlement to MHT. Manifestly, the absence of research investigating the prevalence rate of inmates with covert disorders and/or with differing severity levels, means that there is likely to be an unknown percentage of MDP who are eligible for MHT.

Disorder Comorbidity. There is a lack of research specifically investigated the prevalence rate of MDP with disorder comorbidity or co-occurring disorders. However, it is via the general research in this area that the prevalence of such persons in penal custody has raised some concern. There is growing concern that there is a disproportionate number of mentally disordered persons in penal custody with co-occurring disorders. The group that stands out is MDO with a comorbid substance use disorder. Since the advent of deinstitutionalisation, which will be discussed more fully in

section 1.8., it would appear that mentally disordered persons with a major mental disorder and substance use disorder comorbidity are becoming a significant group in penal custody (Pogrebin and Poole, 1987). Several authors have made reference to the number of offenders with a mental disorder and alcohol and/or drug co-morbidity (Aubrey, 1988; Côté & Hodgins, 1992; Rogers & Bagby, 1992; Teplin, 1991). In the US, for example, Peters and Hills (1993) have estimated that this group constitutes around 3 to 11 percent of the prison population, based on such prevalence rates found in the community, the estimated rates of inmates who are mentally ill, and those who have substance abuse disorders. The extent of this problem is exemplified by the fact that two states in the US have made efforts to adapt existing mental health programs to accommodate this group of MDP and that several other states are preparing to do the same (Peters and Hills, 1993). There is little information in this regard from other western countries. However, comparable changes have been implemented in the CJS and the mental health system across western countries and similar trends have resulted. This means that in line with the US, most western countries are likely to have a significant proportion of MDP with substance use disorder comorbidity.

There is also evidence indicating that there is a disproportionate number of mentally disordered persons with co-occurring disorders, other than substance use disorder, residing in penal custody. This area has not widely been investigated, mainly due to the difficulties involved in diagnosing dual disorders and for simplicity in data analysis. Porporino and Motiuk (1995), for example, coded only the primary disorder for the inmate

participants in their study, however, the authors noted that a significant proportion of these inmates had co-occurring disorders. Hodgins (1995), in her review of the literature pertaining to the provision of MHT for MDP, reported that a number of inmates have been found to have co-occurring disorders. There is little information in this regard in NZ, however, Scandett (1988) found in her study of female inmates, that the majority had co-occurring disorders. This information indicates that extremely vulnerable MDO can reside in penal custody and it also shows that a comprehensive MHS system is essential for the protection of MDP right to MHT.

Closing Comment. The diverse range of prevalence estimates found within the research has produced considerable debate regarding the efficacy of the research in this area. Prins (1993) found in his review of the literature, for example, that the prevalence estimates ranged from as low as 0.5%, to as high as 80%, depending on the disorder in question and the type of penal institution examined. It is widely held that there are likely to be more mentally disordered persons residing in jails rather than in prisons (Hodgins, 1995; Steadman et al, 1989; Wardlaw, 1986). However, this is difficult to quantify due to the diverse criteria employed across studies. Moreover, while there is somewhat of a plethora of research investigating prevalence rates in jails or the equivalent, there is a lack of prevalence research on the rate in prisons (Hodgins, 1995; Jemelka et al, 1993; Roesch et al, 1995). The inclusion of offence related disorders; the emphasis placed on disorder severity and overt disorders, or those with more positive symptoms; and the lack of attention paid to disorder comorbidity,

has skewed the research in this area away from the primary issue of protecting inmates' human rights and away from the policy objective of providing a comprehensive MHS system within this context. What stands out in this discussion is that there is an absence of research investigating the prevalence rate of MDP within the boundaries of the legal context in question.

1.5.3. SECTION SUMMARY.

Survey based data indicates that there is a definite demand for MHS within penal populations across countries. However, because more precise information is essential at the practical level, more empirical research has been undertaken in this area. It is apparent that there is some disparity in the prevalence estimates reported across jurisdictions, countries and between penal institutions. Clearly, the operational definition of a mental disorder and the sample selected largely contribute to the broad prevalence range reported. Nonetheless, in spite of these methodological inconsistencies, the results of empirically based research have provided some clarity regarding the services required. In general, this type of research suggests that there is a higher rate of MDO residing in penal custody than indicated by survey based research. Unfortunately, no empirically based research has been undertaken in NZ, yet it is apparent that there are prison inmates in this country who are likely to have mental health problems that render such persons eligible to MHT. Moreover, while empirically based data is essential to establish a more accurate account of the number of prisoners who are entitled to MHS, there is a dearth of this type of research that has specifically addressed the issue of prevalence rates within the framework of rights.

1.6. PRISONERS' ACCESS TO MENTAL HEALTH TREATMENT.

The second issue that needs to be quantified, to ascertain whether or not MDP's entitlements are fulfilled, is such persons' access to MHS. It is apparent that MDP are totally reliant on the prison system for the provision of MHT. This means that the detection and referral procedure in prisons is vital for MDP access to these provisions and for the protection of such persons' rights. There are two major aspects of this matter that are of interest. The first area of concern is the legal framework depicting the identification process and the basic mechanics of the detection and referral process, especially the use of screening instruments. The second issue is whether certain factors are found to influence the detection or referral process. Unfortunately, there is sparse research in this regard, as most of the literature in this area has focused on the provision of MHS rather than MDP access to such services (Ogloff et al., 1993). The primary aim, however, is to ascertain the general efficiency of the detection and referral process in operation within prisons. While the provision of MHS will be addressed in the next section, what follows is an overview of the available literature regarding these matters in question.

1.6.1. DETECTION AND REFERRAL PROCEDURES.

Legal Framework. As already highlighted in section 1.4., the legal framework depicting prisoners' entitlements to MHS is ambiguous to say the least. The legal parameters depicting the requirements of prison authorities regarding the identification of MDP is no exception. In the case of Ruiz vs. Estelle (1980), in the US in Texas, the court ruled that "evaluation and screening standards" were mandatory (Severson, 1992). This ruling legally affirmed the

importance already placed on screening procedures by many correctional and mental health agencies in the US (Steadman et al., 1987). Nevertheless, court action does not necessarily precipitate the implementation of comprehensive screening procedures. While it is important to have legal confirmation that screening standards are essential, what is pertinent at the practical level is the nature of the detection and referral process. Although screening standards are not mandatory in this country, in accord with other western countries, "crisis screening" at intake constitutes the general standard under policy (NZ Department of Justice, 1988; Steadman et al., 1987; Cox et al., 1988). In other words, the identification of inmates who require the immediate provision of MHS is the primary requirement. This germane policy standard lacks essential clarity regarding the procedures required, which means that the detection and referral procedures implemented is likely to depend on the individual penal management's interpretation of these policy guidelines. Evidently then, because identification standards are governed by policy not a legal enactment, the enforcement of these standards are likely to be problematic (Severson, 1992).

In addition to this factor, the policy guidelines in question function as a minimum standard. To reiterate, across countries and jurisdictions, the aim is to supersede the minimum standards and provide comprehensive MHS. While crisis screening is an accepted minimum standard it is commonly viewed as inadequate for the provision of humane containment, especially within the prison setting (Cohen, 1993). It is apparent that prison authorities are responsible for the well-being of convicted felons for a longer

duration than remanded inmates and that the legal framework depicting MDP's entitlement to MHS is not limited to those in crisis. Although some penal institutions have established independent policy standards, the implementation of the recommended procedures is often problematic (Steadman et al., 1987). Therefore, given the minimum standards in question and the inherent problems with the implementation of policy guidelines, it is likely that there will be reasonable variations in the detection and/or referral procedures found in operation.

Generic Screening Procedures. It is apparent that some form of screening procedure is essential for the detection of MDP. Most prisons have some form of classification system for the security and the general management of the institution. In NZ, for example, to establish security ratings, inmates are classified at admission and periodically while serving a prison term. The security issues involved are such factors as; the seriousness of the current offence, history of violence and mental stability (Superintendent Paparua Prison; Personal communications, 1994). Evidently, it is essential for the day-to-day management of prisons that inmates who may pose a security risk are identified, and mental stability is an issue of concern. Nevertheless, these types of "mental health assessments" are driven by management issues. Therefore, while some MDP may be identified via this process, this method of mental health screening has obvious limitations due to its orientation.

An equally common screening procedure found across countries is what Ogloff et al (1993) refer to as "criminogenic assessments". These types of assessment inventories are primarily designed to

ascertain the general rehabilitative needs of inmates. The "Case Management Plan", which operates widely in NZ penal institutions, falls within this assessment category (NZ Department of Justice, 1988). There are various needs recorded via this schedule such as; scholastic ability, job interests and psychological functioning. Although psychological needs are commonly assessed via criminogenic screening schedules, the needs in question most commonly relate to prisoners' reintegration back into the community rather than humane containment issues. Therefore, while these types of assessment procedures are important for rehabilitation objectives and do identify certain needs of inmates, this type of screening has not been instigated for the detection of MDP. This means that these forms of screening procedures are also likely to have serious limitations for the identification of MDP and the protection of such persons' rights.

Mental Health Screening. It is evident that the aforementioned types of "screenings" are not oriented towards humane containment issues or the identification of MDP. For the provision of humane containment, in many western countries, including NZ, a medical examination at admission is a standard requirement under penal policy (NZ Department of Justice, 1988; 1989; Ogloff et al., 1993). This assessment generally includes a mental health component, which most commonly consists of a few generic questions such as; mental health history and current social functioning. Again it is clear that some MDP may be identified via this screening process, however, due to the brevity of the mental health screening commonly involved in a medical examination it is likely that many MDP will go undetected. Independent from

medical examinations, it is apparent from the available literature that the most widely used screening procedure is a brief inquiry with an inmate by a correctional officer at intake (Roesch et al., 1995; Steadman et al., 1987). Although these types of assessments are better than nothing, whether this method of identification even meets the minimum standards is questionable. Snow and Briar (1990) found that in jails in the US there was a low detection rate with the use of this type of screening. Teplin (1990), for example, undertook research assessing the detection process in a county jail in Illinois, where this method of screening was the primary procedure. Teplin restricted the operational definition of a mental disorder to severe disturbances, nevertheless, she still found that only 62.5% (n = 40) of the severely mentally disordered inmates were detected and appropriately referred. This suggests that when detection is solely dependent on informal inquiries by correctional staff it is likely that even inmates in crisis will be overlooked.

In several western countries and jurisdictions, to comply with accepted minimum standards, standardised screening schedules are more commonly being utilised in penal institutions. Steadman et al (1987) conducted a national survey in the US on the provision of MHS for jail inmates. It was found that 70% of the jails within the study (n = 43) utilised some form of standardised screening schedule to evaluate inmates' current mental health status at intake. The most commonly utilised screening schedules were oriented towards crisis intervention and involved the acquisition of information such as; the risk of self-harm and/or harm to others, the presence of fluid psychiatric symptoms and/or

psychological disturbances. The reliance on crisis based assessments within the jail setting has also been reported elsewhere (Cox et al., 1988; Ogloff et al., 1993). In NZ, the utilisation of standardised schedules for the provision of emergency treatment has become common practice in remand centres. In Addington Prison, for example, the administration of the "Crisis Intervention Screening" schedule is an accepted procedure at admission (Prison Staff at Addington Prison: Personal Communications, 1994). Clearly, crisis based evaluations serve an important function in the identification of inmates who urgently require MHT and this also complies with minimum standards. Nevertheless, crisis intervention screening alone does not constitute an adequate identification process for the humane containment of MDP (Roesch et al., 1995). Although standardised crisis based schedules have a place in the prison system, at best this type of screening simply flags acutely disturbed prisoners who require a more extension evaluation. These schedules are clearly not comprehensive diagnostic instruments as they are inherently insensitive to less salient Axis-1 disorders and to covert symptomatology (Ogloff et al., 1993; Steadman et al., 1987; Teplin, 1991). Therefore, while crisis based evaluations are a step in the right direction, the sole use of these screening schedules does not constitute a comprehensive identification procedure.

Mental Health Assessment Inventories. In some countries and jurisdictions, in the attempt to provide adequate access to MHS, some penal institutions do employ the use of more comprehensive mental health screening schedules. Ogloff and his colleagues (1993) reviewed the utilisation of certain screening schedules

amongst penal institutions in the US. It is not pertinent for this discussion to review the individual assessments utilised. What is important to address, however, is the validity of the assessment schedules most commonly found in operation. In prisons in the US that do utilise more comprehensive schedules, the AIMS[11] or the MMPI-2[12] have generally been the schedules of choice. However, there is a dearth of research available regarding the validity or reliability of these instruments. Ogloff et al (1993) have reported that neither of these two assessment schedules are based on "psycho diagnostic nomenclature". This means that the information collected may be of limited clinical use, regarding both diagnosis and treatment options. Therefore, while mental health assessments are being utilised, it is quite possible that the use of these schedules does not largely improve the rate of identification over and above the detection rate accrued via crisis screening methods.

In recent years there has been more emphasis placed on the utilisation of clinically based assessment inventories (Hodgins, 1995). These types of assessment schedules are more likely to be efficient in the identification of MDP simply because these instruments are based on diagnostic nomenclature. Ogloff et al (1993) have reported that positive results in detection have been found via such schedules as the BPRS[13] and the RDS[14]. At this stage, however, the employment of these schedules has primarily been research based and the focus of the research has been the

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[11] Adult Inmate Management System.

[12] Minnesota Multiphasic Personality Inventory, Second Edition.

[13] Brief Psychiatric Rating Scale.

[14] Referral Decision Scale.

assessment of major disorders (Ogloff et al, 1993; Roesch et al, 1995). Nevertheless, the utilisation of clinically driven mental health assessments appear to be the most promising method of identifying MDP. With the screening for less pervasive disorders included in the assessment process, the use of these inventories is likely to be the most effective method of identification.

Closing Comment. It is apparent that policy guidelines regarding screening procedures are oriented towards minimum standards rather than comprehensive procedures. While there is limited information in this regard it is clear from what is available that crisis screening and criminogenic assessments are the common focus in the detection and referral process (Roesch et al., 1995). Limiting screening for inmates in crisis, especially within the prison setting, means that many MDP who are entitled to MHS are likely to go undetected. In other words, the information available suggests that the accuracy rate of detection and referral for MDP is likely to be reasonable low. Although the issue at hand is the detection of MDP within the legal framework of humane containment, it is apparent that there tends to be an emphasis placed under policy on the rehabilitative needs of inmates rather than humane containment issues. Comprehensive criminogenic assessments appear to be the most common type of screening procedure implemented across penal institutions in most western countries. Not only does this type of assessment appear to be given more weight under policy, but criminogenic information is more readily accessible to correctional staff. For example, primary file information such as; serving a sentence for a sexual offence or having substance

use issues, indicates that such prisoners are potential candidates for related rehabilitative MHT. What this means is that prisoners with mental health problems that are deemed relevant to recidivism issues and rehabilitation issues may be more readily detected and referred than MDP with humane containment needs. In other words, it is likely that the detection and referral rate for rehabilitative MHT will be more efficient than that found for humane containment issues.

1.6.2. PROBLEMS WITH THE IDENTIFICATION PROCESS.

In light of the legal framework in question, it is not surprising that there are multiple problems found within the identification system. One of the major criticisms of the detection and referral process within the US and the United Kingdom has been the over-reliance on correctional officers to perform the initial screening assessment for mental health problems. In most countries, including NZ, even when screening schedules are employed, the administration is primarily the responsibility of correctional officers (Coleman, 1988; Ogloff et al., 1993; Roesch et al., 1995; Steadman et al., 1987). In this country, in line with other western countries, penal officers receive training in the area of mental health (NZ Department of Justice, 1988; 1989), however, Coleman (1988) and Cox et al (1988) point out that the training provided for correctional staff is often limited in nature. Understandably this has raised concern regarding the identification of MDP.

Managerial Issues. Across countries, including NZ, it has been voiced by prison staff, that there are severely disturbed prisoners who would be more appropriately contained within the mental health system (NZ Penal Policy Review Committee, 1982; NZ

Department of Justice, 1988; 1989; NZ Ministry of Health, 1987). The opposition to containing these disturbed and often disruptive inmates in prison by correctional staff has commonly been considered to relate more to management issues than to humanistic concern, due to undesirability of managing such persons. However, the research evidence available does not substantiate this claim. Research undertaken by Kropp, Cox, Roesch and Eaves (1989) shows that the identification and referral of MDP is more likely to be related to correctional staff's general perception of MDO rather than managerial issues per se. Kropp et al (1989) completed a survey on correctional staff's attitude towards MDO and found that MDO were generally viewed as less predictable, more irrational and more dangerous than "normal" offenders. This perception is in line with reports on the public's general view towards MDO (Bartol, 1991; Howells, 1984; Western, 1991). Howells (1984), for example, conducted a study on public ratings of perceived dangerousness in relation of media stereotypes of MDO. It was found that even when the mentally disordered characters, in the factitious cases presented, committed a non-violent crime or had a less severe disorder (schizophrenia versus major depression), such persons were still rated as more dangerous and less predictable than "normal" offenders. This stereotyped view of MDO, although polarised by the media, is primarily based on the definition of a "mental disorder" under mental health legislation. In most western countries and jurisdictions alike, the pre-emphasis under mental health law is that of severity, with respect to the nature and the seriousness of the condition in question, and screening standards stipulated under policy are congruent with this legal definition of a mental

disorder. This means that the detection and referral of MDO may primarily be based on the commitment criteria under mental health legislation. In other words, the focus placed on the referral of disturbed-disruptive inmates by correctional staff may simply reflect the relevant legislation and policy rather than management issues. It is apparent that the major focus under policy has been inmates who suffer from severe major mental disorders and/or those who are likely to fall within the bounds of the commitment criteria under mental health legislation, and that disruptive-disordered inmates are more likely to come within this category of MDP. This alone could contribute to a bias in detection rates observed. Another consideration which is aptly noted by Adams (1986), is that disturbed-disruptive inmates are just as likely to pose management problems within mental health facilities. It has been widely acknowledged that this sub-group of MDO are the most undesired clients in the mental health and criminal justice systems (Adams, 1986; Bartol, 1991; Morrissey & Goldman, 1986; NZ Penal Policy Review Committee, 1982; NZ Department of Justice, 1988; NZ Ministry of Health, 1987; Prins, 1993; Wardlaw, 1983). Clearly then, there is not sufficient evidence to support that there is a management related bias in the identification of MDP. In part at least, the focus on the severely disordered and system conflict could explain the emphasis placed on disruptive-disordered inmates.

Detection and Referral. Another issue that has been raised regarding the reliance on correctional staff in the detection process has been the relationship between detection and referrals. There is research evidence that shows that referrals made by

police officers are not directly related to their perceptions of mental illness per se. Teplin and Pruett (1992) and Holley and Arboleda-Florez (1988) undertook research investigating the referral process at police level. Similar results were found in both studies, in that there was a disparity between referrals and the detection of mental health problems. In general, police officers were found to refer only persons they considered would meet the treatment criteria stipulated by mental health agencies rather than all those perceived to be disordered. This suggests that police officers are performing an informal assessment process at detection level. This finding is not incongruent with findings obtained by Steadman and his colleagues (1987), regarding correctional officers within the jail system. It was found that detection did not necessarily automate a referral to MHS. A referral to MHS was most commonly executed under emergency situations only. This indicates that correctional staff may also be conducting an informal selection process in regard to the availability of MHS. Research by Toch and Adams (1988), comparing the approach of correctional and forensic mental health staff towards disruptive mentally disordered prisoners in a New York State prison, is also in line with the above findings. The forensic staff were naturally more able to differentiate between behaviour symptomatic of a mental disorder and eccentric behaviour, yet considerable agreement between correctional and forensic staff was found. However, there was less agreement regarding the appropriateness of action taken, as correctional officers were less likely to recommend treatment. This suggests that some prisoners, although detected as mentally disordered by

prison officers, may not to be referred for treatment based on prison staff's view of service availability.

Time of Screening. Screening procedures, in the broadest sense, are most commonly performed at admission. As highlighted earlier in this discussion, there is a reasonable degree of evidence showing that the act of incarceration and the prison environment have an exacerbating effect on vulnerable individuals. It has consistently been found that, at the initial stage, the impact of incarceration is a considerably volatile period for vulnerable inmates. For example, this has been found to be a particularly high risk period for drug-withdrawal, disorientation and suicide (Bartol, 1991; Reali & Shapland, 1986; Steadman, McCarty, & Morrissey, 1989; Axelson & Wahl, 1992). It is apparent that the identification of MDP at this time is the most desirable procedure, due not only to the vulnerability of inmates at this time but also because early detection provides clear advantages for penal management and inmates alike. However, it can not be overstated that while identification at intake is an adequate procedure for penal facilities housing remanded inmates, it is not sufficient within the prison setting (Roesch et al., 1995). The issue at hand is that, throughout the term of imprisonment, some prisoners may develop further symptoms or may exhibit the first signs of mental health problems. As mentioned earlier, there is reasonable documentation showing that convicted prisoners may show clear signs of mental disturbances while serving a prison term. This means that administration of mental health screening at admission **only** is not an adequate identification process within the prison setting. In prisons it is apparent that, while detection procedures

are essential at intake, it is of equal importance to implement follow-up screening procedures (Jemelka et al, 1993; Ogloff et al, 1993; Peters & Hills, 1993). Therefore, given that mental health assessments are commonly reliably available only at intake, it is likely that many MDO will go undetected.

Cost Efficiency. While the primary objective is to employ screening inventories that will accurately identify MDP, the procedure implemented must be cost effective. Ogloff et al (1993) found that there was a negative relationship between the level of detection accuracy and the cost involved. In other words, the more costly assessment programs appear to be more efficient in the identification of MDP. The clinically based screening schedules are generally the most effective yet the most expensive to deploy. This is due to a combination of the time involved in administration and the employment of mental health professionals to perform the assessments (Coleman, 1988; Hodgins, 1995; Ogloff et al., 1993; Pelissier, 1988). Such factors obviously prohibit the willingness to utilise these schedules. While fiscal resources clearly constitute the outer boundaries that dictate the procedures employed, short-term costs should not be used to justify human rights infringements. Hodgins (1995) aptly notes that, while it is costly to properly assess and diagnosis inmates, it is actually more costly to misdiagnose. What this indicates is that the cost of implementing an identification system with clinically based mental health screening schedules is likely to be a major reason why less expense and less efficient methods are deployed. Clearly this decreases that likelihood of having an efficient identification system and increases the likelihood that MDP will go undetected.

Closing Comment. It is clear that across countries, there are some generic problems involved in the detection and referral process. The fact that correctional officers are commonly responsible for the initial screening does raise some concern. Officers have the primary responsibility of custodial safety (for fellow staff and inmates), which limits the time available for human resource duties and may sometimes present a role conflict (NZ Department of Justice, 1988). The absence of a comprehensive legal framework, however, is the point of most concern. With clearly defined legal requirements practical issues such as cost efficiency could be more accurately addressed. For example, it has been established that para-professionals are able to administer clinical mental health assessments satisfactorily when adequate training is provided (Coleman, 1988). This should lower the cost while still providing the most efficient type of screening schedules. Moreover, with precise role requirements there is less likely to be the sense of role conflict for correctional staff. An explicit denotation of the function of the identification process should also reduce the likelihood of correctional staff resisting referring detected MDP because of extraneous matters. What is apparent is that most of the generic problems found in the detection and referral process seem to be integral to the equivocality of the legal framework in question.

1.6.3. PREDICTORS OF DETECTION AND REFERRAL.

The apparent absence of a comprehensive legal framework for the detection and referral system arguably allows for extraneous variables to influence this important process. This raises the question as to what factors come into play in the operational

detection and/or referral process. Unfortunately, there is a dearth of empirical research in this area. Teplin (1990) investigated this issue in a county jail in Illinois. She found that mental health history recorded on file, overt symptomatology, the nature of the arrest, schizophrenia and depressive symptoms had a positive influence on detection. Aubrey (1988), obtained similar results in a comparative analysis on competency referrals and non-referrals. He found that previous MHT, previous court referrals, previous convictions and the nature of the arrest were factors that had an impact on being referred. These findings are consistent with information gathered by Steadman et al (1987) in their extensive survey on jails in America. It was found that mental health history and the presence of fluid psychiatric symptoms had the most influence on detection. Collectively these findings provide some insight into the detection and referral procedure, however, this research has examined remanded inmates rather than convicted felons. What this means is that court related issues, such as a court ordered assessment, may come into play at this level and influence this process. It is unlikely that such factors would influence the detection and referral process for convicted inmates. Nevertheless, these findings do indicate that recorded previous mental health problems and current signs of overt symptomatology may be the most influential factors involved in detection of MDP.

There is an absence of empirical research that has directly sought to establish what factors influence the detection and/or referral process in the prison setting. As discussed in the previous sub-section, one issue that has commonly been raised is the referral of

disruptive-disordered prisoners. Irrespective of the controversy surrounding this issue, the fact remains that disruptive-disordered prisoners may be most likely to be detected and referred for treatment. It is apparent that mentally disordered persons with fluid psychotic symptoms can be non-compliant, which is likely to disrupt routine prison management. This alone suggests that this group of MDP is more likely to be visible to staff and subsequently detected. More directly, Adams (1986), investigated the relationship between disciplinary infractions and referrals to MHS for inmates in two New York prisons. It was found that referred inmates had higher infraction rates than non referred, which is congruent with the claim that disturbed inmates who are disruptive are more likely to be identified and/or referred for treatment. Moreover, as highlighted earlier, MDP who fall within this disruptive-disturbed category are also likely to come under the legal definition of mentally disordered in accordance with mental health legislation. Given the apparent reliance on this legal definition and the visibility of distress, it is likely that disturbed-disruptive prisoners are the most commonly detected and referred MDP.

As mentioned in section 1.4., it has been suggested that the personality of prison authorities has a significant influence on how a penal institution is operated. It is not unlikely that the personality of the *inmates* in question may be another factor that influences detection. Although there are no specific research findings in this regard, there is some indirect evidence available to support this supposition. The research evidence in question primarily comes from investigations examining the relationship

between personality types and mental disorders. The Temperament and Character Inventory (TCI), designed by Cloninger and his colleagues, has been found to be a useful tool for discerning different personality types in disordered populations. Bulik (1994), for example, investigated the reliability of the TCI to group women with bulimia nervosa. She found that the use of this inventory had a significant influence in discerning women with this disorder who had a concurrent personality disorder from whose who did not. Similar significant findings have been obtained with other disordered populations, such as those with substance use disorder (Earleywine, Finn, Peterson & Pihl, 1992). This type of research indicates that personality type may influence symptom manifestation, which has important implications regarding such issues as treatability and treatment selection. Rogers and Webster (1989), for example, discussed the issue of the treatability of MDO and reviewed the pertinent literature. It was highlighted in this review that personality type has been found to be a significant factor in treatment success. Clearly this type of research has important implications regarding the identification of MDP. More pertinently, this literature suggests that correctional staff may rely on personality traits in the identification process.

In line with most western countries there have been multiple governmental inquiries in NZ, regarding the containment of severely mentally disordered persons in penal custody. The problems found in the management of inmates with personality disorders have commonly been addressed (NZ Ministry of Health, 1988). This suggests that, while polarised maladaptive traits are

likely to be detected, correctional staff are in tune to differing personality types. Hodgins and Côté (1993) conducted a study comparing the criminality of mentally disordered and non-mentally disordered inmates residing in Canadian penitentiaries in Québec. The point of interest is that Hodgins and Côté found that mentally disordered inmates with ADP had a similar criminal history as non-mentally disordered inmates with APD, which was not that dissimilar from non-mentally disordered inmates without APD. In other words, mentally disordered inmates without APD stood out from the rest of the study sample. This finding suggests that personality factors may relate to detection, in that, mentally disordered inmates who do not exhibit typical "criminal" personality traits may be more easily identified by correction staff as "abnormal".

It accord with this somewhat indirect evidence that typical criminal traits may reduce the chance of detection, it is also likely that substance use comorbidity issues may decrease the likelihood of being appropriately detected and referred. As discussed in section 1.5., the prevalence estimates indicate that there is a disproportionate number of inmates with substance use problems, which is not that unexpected given the criminal aspect commonly involved in such abuse (Prins, 1993). This suggests that alcohol and drug problems may be perceived by correctional staff as typical criminal traits, thereby reducing the chance of a referral. This postulation concurs with research evidence that will be discussed more fully in section 1.8., where it has been found that mentally disordered persons with substance use comorbidity issues appear less likely to be diverted for MHT

(Belcher, 1988; Freeman & Roesch, 1989; Palermo et al, 1991; Pogrebin & Poole, 1987). This means that it is likely that substance use issues may have an impact on detection within the penal system.

Closing Comment. It is apparent that there is a significant absence of research investigating the issue of detection in prisons. Nevertheless, the available literature does indicate that factors relating to chronicity are likely to be the most influential in the detection and referral process. In other words, current severe overt symptomatology and previous mental health problems are likely to increase the chance of detection. Although indirect, there is literature that suggests that personality traits are also likely to come into play. What the literature indicates is that MDP with atypical "criminal" personality characteristics may be more likely to be appropriately detected and referred.

1.6.4. SECTION SUMMARY.

It is evident that there are multiple problems involved in the detection and referral process within penal institutions. The legal requirements primarily constitute policy standards which are generally found to be vague and imprecise. While there appears to be a move towards the use of more comprehensive mental health screening schedules, the literature indicates that crisis screening at intake is the most common form of assessment. The other prominent problem is that there appears to be an over-reliance on correctional officers in the identification process. When solely relying on these types of assessments it is likely that the majority of MDP may go undetected. In fact the literature indicates that even severely disordered inmates can go undetected

with the use of crisis screening. In light of the various problem involved in this process, the detection and referral system in operation in most penal institutions, is likely to function below the legal minimum standards, rather than beyond, placing MDP at risk of human rights infringements.

Criminogenic schedules appear to be the most prevalent assessments and seem to be the most structured element of the identification process, which reflects that rehabilitative needs are the dominant focus under policy rather than humane containment requirements. Clearly this indicates that prisoners with rehabilitative mental health needs may be more readily detected and referred than MDP with humane containment requirements. Finally, while there is a dearth of empirical research investigating MDP' access to MHT, the available research suggests that; mental health history, current disorder type and disorder severity are the most significant factors involved in identification and that personality traits may also play a significant role in the detection and/or referral process. What this suggests is that MDP who suffers from a severe major disorder and has atypical "criminal" personality characteristics is more likely to be detected and referred. It is apparent that improvements are required as this process is pivotal to the fulfilment of MDP entitlement to MHT. However, before any changes are implemented, empirical research is essential to directly quantify this operational system within the framework of prisoners' rights.

1.7. THE DELIVERY OF MENTAL HEALTH TREATMENT.

The provision of MHT is clearly the final issue of concern regarding the fulfilment of MDP entitlements. While the provision of MHT is dependent on the identification process, the delivery of treatment is largely an independent system. As highlighted in section 1.4, the provision of MHS for prisoners is not widely disputed as an essential requirement for humane containment, yet the nature of the services required is subject to debate. The matter of concern is whether the delivery of MHT adequately caters for the demand for MHS within the legal framework of humane containment. There are four aspects of this issue that are pertinent to this discussion. The first issue is the legal framework in this regard and whether the legal requirements sufficiently sanction the protection of MDP' right to treatment. The second issue is what types of MHS are generally available for prisoners and whether such provisions comply with the legal framework in question. The response in this area has varied across countries and jurisdictions, however, the point of interest is the general trend in the provision of MHS across countries. The provision of rehabilitative MHT, while not within the bounds of MDP' entitlement to MHT, is relevant to this inquiry. Subsequently, the provision of rehabilitative MHS will also be briefly outlined in this section. As has already been established, what is technically available is not necessarily accessible at the practical level. Therefore the third matter that is discussed in this section is the common problems found across countries in the MHS system for prisoners and how these difficulties appear

to influence the type of MHT provided in real terms. This leads to the final issue of concern, which is what factors appear to influence treatment delivery for MDP. Who is actually provided with treatment is indicative of the availability of MHS at the practical level and of the level of the protection afforded for this right to treatment.

1.7.1. THE LEGAL REQUIREMENTS FOR THE PROVISION OF MHS.

Legal Requirements. Across countries and jurisdictions the framework depicting the legal requirements for the provision of MHS is commonly found to be more tangible than the legal parameters depicting the detection and referral process. In section 1.4., the generic legal framework for the provision of MHS was discussed. It was highlighted that, across most western countries there is legislation that addresses the provision of MHS, which is based on internationally recognised minimum standards. More specifically, the most relevant standard in this regard, is Principle 22 of the United Nations Standard Minimum Rules for the Treatment of Prisoners (1955). Under sub-section 1 of this principle, it is stipulated that "...At every institution there shall be at least one qualified medical officer who should have some knowledge of psychiatry...". As is comparable to other western nation, under NZ law, the pertinent legislation is closely linked with these minimum standards. Section 6 sub-section 3[15] of the NZ Penal Institutions Act 1954 largely mirrors sub-section 1 of principle 22. However, there is no requirement under this sub-section of the Act for the employment of a medical officer with knowledge of psychiatry.

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[15]It is stated under section 6 sub-section 3 that " For every institution there shall be one or more medical officers, each of whom shall be a medical practitioner ..."

The only reference made in this regard, under this Act, is in sub-section 2 of section 6, where it is stipulated that "...The Secretary of Justice may...employ...chaplains, counsellors, education officers..." as required. While this latter sub-section acknowledges that the state has the legal duty to provide mental health related services for inmates, the purpose of providing these services and the actual services required are not clearly stated. It is also stipulated under sub-section 1 of principle 22 that "...The medical services...shall include a psychiatric service for diagnosis and...treatment...". The relevant provision under NZ law is located under part four of the NZ Penal Regulations 1961 where the duties of psychiatrists are stipulated. This regulation covers the requirement to perform psychiatric examinations[16], which shows that the provision of psychiatric services is a legal requirement. Nevertheless, while this legal requirement is likely to constitute the provision of diagnosis and treatment, which is in accord with internationally set standards, the requirements of this legal sanction is largely subject to interpretation.

The final minimum standard pertinent to this discussion is MDP's access to "specialised care". It is stipulated under sub-section 2 of principle 22 that "...Sick prisoners who require specialist treatment shall be transferred to specialised institutions or to civil hospitals...". In NZ, in line with most common law based societies, MDP's legal entitlement to access to this type of care is verified under mental health law rather

[16]It is stipulated under section 138 sub-section 1 of these regulations that "... from time to time ... initial and subsequent ... examinations ..." shall be conducted as required.

than penal legislation[17]. Under the relevant sections of the NZ MHA 1992, prisoners may be transferred to a psychiatric facility based in the community if, in accord with clinical judgement, this form of action is deemed essential for such persons' care. This legal provision clearly complies with internationally set standards, however, it is also tenuous in nature. In NZ, in line with other western nations, while the legal sanctions verify prison authorities' legal duties to provide prisoners' with access to MHS, the types of services required are not clearly elucidated. Given the aforementioned legislation it is apparent that hospitalisation is the most definitive legal requirement for the provision of MHS, yet, in line with the sanctions for psychiatric examinations and counselling, the practical delivery of these forms of MHS are subject to interpretation. As has already been highlighted, while there is pressure for amendments in the legislation to affirm better legal protection for MDP, across most western nations, the provision of social resources tends to be deemed a policy issue rather than a legal mandate (Cohen, 1993; Severson, 1992). This means that the nature of the MHS provided is largely governed by policy rather than legislation per se.

Policy Objectives. It can not be over-emphasised that the commonly held policy objective is to *surpass* minimum standards and provide a comprehensive MHS system. As previously discussed, however, generic goals stipulated under policy require a structured and detailed set of standards to be tangible. Subsequently, as stated in section 1.4, various

[17] As referred to in section 1.4., prisoners may be tranferred to a psychiaric hospital under section 45 or 46 of the NZ MHA 1992.

correctional departments and/or mental health agencies have set more specific policy guidelines and/or codes of treatment. In the New York State prison system, for example, the primary agencies involved in the provision of MHS have established fundamental policy objectives for the provision of such care (Dvoskin & Steadman, 1989; Greene, 1988). As Greene (1988) reports, the major objectives are; "to reduce the disabling effects of psychiatric illness", "to alleviate needless human suffering" and "to help make prison a safer place in which to live and work" (pp. 387). More detailed policy aims are also established in this country. Under NZ policy guidelines the primary objectives for the provision of MHS are; to provide "humane containment", to facilitate in the "management of prisons", to reduce the "harmful effects associated with imprisonment", to reduce the "likelihood of reoffending" and to assist the "reintegration of inmates into society" (pp. 21, NZ Department of Justice, 1988). These policy objectives are clearly oriented towards the provision of services beyond the minimum requirements. However, in line with the relevant legislation, the nature of the services required to fulfil these objectives are not adequately depicted under these policy standards.

Closing Comment. In most western nations, including NZ, MHS are required under the respective penal legislation for the provision of humane containment. Unfortunately, the legal requirements are generally found to be ambiguous and commonly constitute the minimum standards for provisions. Although minimum standards of care are the most legally binding

protection of MDP' human rights, across most western countries, the fundamental aim under policy is to provide a comprehensive MHS system for the humane containment and the rehabilitation of inmates. However, the types of MHS required are not clearly stipulated via legislation or policy. Not only are the most binding legal requirement minimum standards but, as previously discussed, the implementation of policy standards is commonly problematic. Therefore, as highlighted in section 1.4, what this means that there is likely to be a gap between MDP' paper rights to MHT and the practical delivery of treatment. The critical question at this point is whether the types of services provided are congruent with policy standards and constitute the provision of a comprehensive MHS system.

1.7.2. THE TYPES OF MHS AVAILABLE FOR PRISONERS.

In most western countries, including NZ, the provision of MHT for MDP has traditionally been deemed the responsibility of the mental health system. Prison authorities have long had the option to transfer a MDP to a mental asylum, which commonly functioned as the primary source of MHT for MDP. Understandably, however, the field of mental health and the mental health system have evolved since the advent of the early mental asylums (Durham, 1989; Grob, 1991; Haines & Abbott, 1985; Jones, 1993; Morrissey, 1986). In conjunction with changing social attitudes and various socio-political factors, the responsibility of providing MHS for offenders is now commonly shared between the CJS and the mental health system. Across countries, in most penal institutions, the provision of MHS is generally provided via various mental health agencies,

funded either by the department of justice or the mental health department (Greene, 1988; NZ Department of Justice, 1988; Miller, 1992; Prins, 1993; Steadman et al., 1987). An indepth review of the multiple service providers is not pertinent to this discussion. The point of interest is the types of MHS commonly made available for prisoners across countries.

Community Based MHS. A transfer to a community based psychiatric hospital is still available today and constitutes an important provision for the protection of MDP' rights (Baker, 1993). Across countries, with the advent of deinstitutionalisation there are now a variety of inpatient psychiatric facilities. In accord with the concept of mental asylums, most countries have a secure mental hospital within the community. In England, for example, there are three "special hospitals" that serve as maximum security hospitals for dangerous, violent and criminally-minded patients for England, Wales and Northern Ireland (Prins,1993; Wardlaw, 1983). Atascadero in California is a high security mental hospital for both civil and criminal patients and constitutes an American equivalent to the English special hospital. In NZ under section 100 of the MHA 1992, the minister of health may gazette[18] a hospital as part of a psychiatric security institution. At present this is the case with the National Security Unit on the Lake Alice site in Marton, NZ (Ministry of Health, 1995; Personal Communications). Again, this unit serves a similar function as the special hospitals.

[18]Legally binding offical announcement.

The inpatient capacity of psychiatric hospitals is not commonly described in relation to security ratings. Nevertheless, what is commonly found across countries and jurisdictions, are open-wards (or minimum security units) and inpatient facilities for forensic based services (or medium security units). In NZ, for example, there are eight psychiatric hospital located throughout the country, two of which are private facilities. The majority of the inpatient care available is within the open-ward setting. However, in most central regions there is a small medium secure unit available, such as; The Mason Clinic in Auckland and Te Whare Manaaki at Sunnyside Hospital in Christchurch. The provision of a psychiatric unit within an open-ward setting in a general hospital is also commonly found across countries, including NZ (Ministry of Health, 1995; Personal Communications). Although there is a de-emphasis on security, MDP are still eligible to be transferred to these facilities. Most psychiatric hospitals and some general hospitals also commonly provide outpatient access for treatment (Hodgins, 1988; Høyer, 1988; Prins,1993; Wardlaw, 1983). In NZ, the regional forensic service falls under the authority of the ministry of health and provides a range of services for the prisoner population (Ministry of Health, 1995; Personal Communications).

Prison Based MHS. The prison based services available commonly range from inpatient care through to group therapy for less pervasive mental health issues and also includes rehabilitative services (Hodgins, 1988; Johnson & Hoover, 1988; Wardlaw, 1983). The most common form of specialist MHS for prisoners is the provision of small psychiatric units in major

prisons. In New York State and North Carolina, in the US, this model is the primary avenue for treatment delivery to prisoners. In New York State, for example, this treatment delivery system primarily consists of a central hospital with small satellite units at the major prisons, and also includes a central referral and assessment unit (Dvoskin & Steadman, 1989; Greene, 1988). In the English prison system, some prisons provide small psychiatric units similar to the satellite model (Bartol, 1991; Prins, 1993). The most notable service available in England is Grendon Psychiatric Prison. This prison has received a great deal of notoriety due to its founding efforts to assimilate therapeutic programmes within the prison setting. This prison was originally established to provide psychiatric treatment for MDP, however, its primary contemporary function is the co-ordination of service provision for other prisons (Prins, 1993; Wardlaw, 1983). In NZ, based on the English model, there is a "special needs" unit in the Auckland region to cater for the whole prison population. This small unit is specially designed to provide inpatient care for acutely ill MDP (NZ Department of Justice: Personal Communications, 1994). Another form of penal based inpatient care is regional forensic psychiatric centres. This system is endorsed in Canada and consists of three regional psychiatric centres with inpatient facilities. This service is funded by the justice department and is designed to provide MHT for MDO, including MDP (Hodgins, 1988; Wardlaw, 1983). The MHS provided under the authority of the Federal Bureau of Prisons, in the US, is similar to this Canadian model. Central to this MHS system are three regional psychiatric referral and assessment centres, with inpatient facilities. This

service also caters for the wider range of MDO, including offenders found incompetent to stand trial and not guilty by reason of insanity (Johnson & Hoover, 1988). Additionally, in NZ, for example, in line with other western countries, the department of justice has a Psychological Service division (Barbara Hudson, 1987; Jemelka et al., 1993; NZ Department of Justice, 1988). This division caters for a wide range of offenders' needs such as; probation services, welfare needs, rehabilitative services, and humane containment provisions. Prisoners are one of the many offender groups this service caters for, nevertheless, it is under the authority of this department that psychologists, social workers and counsellors are commonly deployed to provide MHT for prisoners (NZ Department of Justice, 1988). Across countries and jurisdictions, prisons commonly have an inpatient medical unit sited within each institution. These units primarily cater for the medical needs of prisoners, nevertheless, mental health related issues are also attended to. While these units are generally quite small, this appears to be the most prevalent form of prison based inpatient care facility available for MDP (van Zyl Smit & Dünkel, 1991).

Rehabilitative MHT. As previously discussed, the rehabilitative objective for MHT is commonly more clearly defined under policy. In accord with this policy objective, rehabilitative MHS appear to be readily available across countries. Rehabilitative MHT is commonly provided from the community based and prison based sector. Severson (1992), in her review regarding the provision of MHS in America, found that there were specialist

substance abuse and sex offender programmes available at most prisons in the US. The same has been reported in Canada (Hodgins, 1988), Scandinavian countries (Høyer, 1988) and the United Kingdom (Prins, 1993). The situation in this country is not dissimilar. In Christchurch, NZ, for example, Odyssey House and Queen Mary Hospital specifically deal with persons with drug and alcohol problems, including inmate clientele, and the Kia Marama treatment unit for sex offenders is available at Rolleston Prison. Most of the services already mentioned also provide rehabilitative MHT. For example, a prisoner may be provided community inpatient care for rehabilitative treatment needs rather than humanitarian issues. The most prominent type of rehabilitative MHS found across countries, is in line with the Psychological Services Division of the Department of Justice found in NZ. As already highlighted, this service caters for the mental health needs that fall within the bounds of humane containment principles, however, the primary focus of this service is the rehabilitation needs of many offender groups (NZ Department of Justice, 1988; 1994).

Closing Comment. There is some variation in the way the provision of MHS has been addressed, nevertheless, there are several similarities in the types of MHS made available across countries and jurisdictions. The general trend found across countries is that there is a reasonable range of services that prisoners technically have access to, from the community sector and from the penal based system. In other words, the types of services available for prisoners appears to comply with policy standards and constitute a comprehensive MHS system.

However, what appears to be available on the surface does not necessarily match what is available in practice. Therefore, to ascertain availability in real terms, the next matter that needs to be elucidated is the accessibility of the available MHS.

1.7.3. ACCESSIBILITY DIFFICULTIES AND CRISIS INTERVENTION.

Given the problems involved in the identification system, it is of little surprise that there appear to be several difficulties involved in the treatment delivery system. As discussed in section 1.5, accurately quantifying the demand for MHS is essential for the protection of MDP' rights. Clearly the relationship between the demand for and the supply of services is indicative of accessibility to such services in real-terms. The matter of resource limitation has become a primary issue of concern in this area. This is mainly because of the general reduction in MHS in the community and the burgeoning prison populations commonly found across western countries. The point at hand is that, with fewer resources for services and an increase in prison numbers, this is likely to prevent a "comprehensive" MHS system from providing "comprehensive" treatment delivery. The major concern is that *crisis intervention* may be the primary type of treatment provided within prisons.

Resource Limitation: Community Based. While prisoners are technically eligible clients for a broad range of services within the community, all such service systems have finite resources available. However, as highlighted in section 1.4, in several western countries MHS have become somewhat of a *scarce* resource in the community. The mental health system has

commonly been subject to major restructuring, with the implementation of the twin policy of deinstitutionalisation and community care being the latest major shift in most western countries, including NZ. The implementation and the broader implications of this policy change will be discussed more fully in the following section. The point at hand is that this twin policy is commonly viewed as the major contributor to a reduction in the availability of community based MHS for the prison population (Baker, 1993; NZ Department of Justice, 1988; Prins, 1993; Rice & Harris, 1993). Reducing the level of resources clearly increases the level of competition for these services. With the current social attitude toward offenders, in conjunction with the equivocality of the legal framework in question, the concern is that prisoners are the least likely group to be afforded the use of these scarce community resources.

The provision of scarce inpatient resources has been the primary point of concern in this area. In several western countries, there is a serious limitation in bed capacity, where the majority of psychiatric hospitals often have lengthy waiting lists (Bob Hudson, 1991; NZ Department of Justice, 1988, NZ Ministry of Health, 1988; Pogrebin & Poole, 1987; Verdun-Jones, 1989). This means that MDP who are deemed committable, in accord with mental health legislation, may not be granted admission. In several western countries there appears to be a general reduction in the transfer of MDP to psychiatric hospitals. Similar difficulties in transferring prisoners have been reported in; the US, Canada (Hodgins, 1988), England (Prins, 1993; Verdun-Jones, 1989), Scandinavian countries (Høyer. 1988) and

NZ (NZ Ministry of Health, 1987). While there is little empirical research investigating this issue, the current transfer difficulties have largely been attributed to the *failure* of this twin policy. Grounds (1991), for example, examined the transfer of sentenced prisoners to Broadmoor psychiatric hospital in England over a 23 year period. He found that while the prison population was increasing over time the rate of transfers was declining. It was also found that there was a longer waiting period, in the later years, between a referral and a transfer. Grounds concluded that these changes in transfer accessibility could be directly related to the implementation of this twin policy and the associated changes in legislation. The transfer of inmates has been the subject of several governmental inquiries in this country. The observations recounted in the Mason Report (1987) are congruent with Grounds findings, in that, a hospital transfer for sentenced prisoners was more readily accessible for prison authorities in the Auckland region in the early 1980's than at the end of the decade (NZ Ministry of Health, 1987). In other words, there has also been a notably decline in transfer rates in this country since the implementation of the twin policy of deinstitutionalisation and community care. Dawson (1987), for example, found that only one sentenced inmate was transferred from a Auckland prison during the year of his research. This means that although this group of offenders is commonly still eligible to this type of care, the accessibility of inpatient treatment in the community appears to be limited.

Resource Limitation: Prison Based. As already highlighted, across several countries, corrections is another social system

that has also experienced a reduction in fiscal revenue in recent years. Furthermore, while an indepth review of the debate regarding the provision of prison based MHS is not pertinent to this discussion, it is important to note that there has been long-standing opposition in this regard. There are two main arguments against such services which are worth mentioning. First, there is the view that providing MHS exclusively for offenders is a waste of valuable social revenue, as this approach necessitates the duplication of MHS already established in the community. The second major point of opposition is that the provision of treatment in the prison setting is assumed to inhibit therapeutic endeavours due to the punitive nature of the prison environment (Bartol, 1991; NZ Ministry of Health, 1984; Wardlaw, 1983). While there is some validity in both of these arguments, this does not negate the fundamental need for such MHS. The point at hand is that with the clear need for MHS within the prison setting such provisions, while scarce, have been established over time despite the continual controversy. However, the long-standing debate regarding the legitimacy of such services is likely to make the provision of prison based MHS more vulnerable to down sizing given the economic climate. What this means is that these scarce resources are likely to become even more unattainable.

As already highlighted, MDP' access to inpatient treatment is not restricted to community based provisions. Again, however, the level of penal based inpatient facilities does not appear to be sufficient to constitute a comprehensive system. Like the community based facilities some penal based systems provide

for several patient categories. As previously discussed the regional forensic psychiatric service in Canada and federal bureau of prisons service, in the US, provide MHT for the broader classification of MDO, including those found UFP and NGRI. Manifestly the provision of treatment for MDP is not the sole objective of these service providers (Wardlaw, 1983). Pelissier (1988) points out, for example, that the inpatient facilities available under the authority of the Federal Bureau of Prisons is just under the bed capacity of 700. Given the survey estimates that around 6% of the penal population in question are mentally ill, the demand for inpatient care is likely to be appropriately 2600. This suggests that the majority of chronically MDP are not likely to receive inpatient treatment from this service. Prins (1993) has reported that the situation is not dissimilar in England. The demand on the facilities within the prison system are exemplified by Grendon Prison's lengthy waiting lists. It is also clear that the number of the small special needs units located at the major prisons is unlikely to meet the demand for these services. This has also been found in the US with the availability of satellite units. For example, the New York State system has approximately 332 beds available for an inmate population exceeding 40 000 (Greene, 1988). This means that even when the demand for inpatient care is based on the most conservative estimate of 5%, the required level of inpatient care tallies to 2000 placements. The situation in NZ is no exception. The special needs unit in Auckland has a bed capacity of 8 and caters for the national male penal population of approximately 3700 sentenced inmates. Again, if the conservative estimate of 5% is taken as the required level for inpatient care, this mean

that demand would be around 240 placements. These conservative estimates highlight that access to penal based inpatient treatment is also likely to be insufficient to cater for the demand.

Resource Limitation: Other Types of Humane MHT. There is less information available regarding the provision and accessibility of other forms of MHT under the humanitarian objective. Furthermore, as discussed in section 1.5, there is also less information available regarding the prevalence of prisoners with less salient disorders that fall within the parameters of prisoners' constitutional right to MHT. Manifestly, it is somewhat difficult to quantify the accessibility of these forms of treatment. However, because most services provide various forms of treatment, it is likely that the accessibility of other forms of MHT is in line with the provision of inpatient care. In NZ, for example, the Psychological Services Division is, as highlighted previously, responsible for the provision of various types of MHT including humanitarian based treatment for prisoners. This department has had a recent reduction in available expenditure, which has brought a subsequent reduction in the service provision allotted for prisoners (NZ Department of Justice, 1994). What this means is provision of MHT from this service is unlikely to adequately cater for the demand, indicating that non-hospital treatment is also likely to lack accessibility.

Resource Limitation: Rehabilitative MHT. As discussed in section 1.3, the prevalence rate of prisoners who require rehabilitative MHT is likely to be a reasonable number.

Manifestly, it is not surprising that it has been reported across countries that the demand of rehabilitative MHT is likely to outweigh the supply of these services (NZ, Department of Justice, 1988; Severson 1992). The current trend in resource reduction and increasing prison numbers is likely to widen this gap between supply and demand. However, as discussed previously, the provision of rehabilitative MHT is not found to be a legal mandate nor does it fall within the bounds of humane containment, across western countries (Severson, 1992; Cohen, 1993). Nevertheless, while the emphasis on rehabilitative goals has fluctuated over time, the provision of such treatment is commonly found to be an important objective under penal policy (Pelissier, 1988). This suggests that rehabilitative MHT is more likely to be offered than humane containment based MHT. As evidenced in the preceding sub-section, this form of treatment appears to be more readily available to the prison population than humane containment based MHT. A review of treatment provision, conducted by Rice and Harris (1993), adds further support to this postulation. They found that treatment delivery was more criminogenic oriented than humane containment bound. Dvoskin and Steadman (1989) also found that rehabilitation was a primary objective in the provision of MHT. This concurs with the criminogenic focus found at detection level. Therefore, while the reduction in resources appears to have had an impact on the availability of rehabilitative MHT, it is likely that in line with the detection process, the delivery of rehabilitative treatment may be more prevalent than the delivery of humane containment based MHT.

System and Service Co-ordination. Adequate co-ordination between systems and service providers is crucial for the efficient delivery of treatment (Hodgins, 1988). Unfortunately, this has commonly been one of the main management problems found across countries. There are two primary problem areas pertinent to this discussion. The first is the co-ordination between the identification system and the MHS system. As previously discussed, correctional staff are primarily responsible for the detection and referral of prisoners, whereas treatment delivery is ultimately the responsibility of mental health professionals. As discussed in section 1.4, the generic working philosophy of correctional staff and of mental health professionals is quite disparate, however, the operational objective of identification and treatment delivery are the same. It is due to this disparate and sometimes opposing philosophy base that conflict appears to arise between these interactive systems (Casey, Keilitz & Hafemeister, 1992; Coleman, 1988; Cox et al., 1988; Hilkey, 1988; Rice & Harris, 1993). Snow and Briar (1990), for example, reported that there appears to be a serious absence of co-ordination between jail authorities and community mental health agencies in most states in the US. On the one hand correctional staff have been reported to question such issues as; prisoners motivation for requesting MHT, the validity of the provision of MHS for prisoners, and the provision of treatment opposed to punishment. On the other hand, it has been reported that mental health providers have questioned such issues as; correctional staff's ability in detection and the validity of the referral of certain prisoners, especially disruptive inmates (Menzies, Gillis & Webster, 1992; NZ Ministry

of Health, 1987). Clearly, what this represents is a certain degree of professional scepticism, that amongst other factors, is most likely based on a lack of mutual respect and understanding of each group's working philosophy (Hafemeister, 1991; Steadman, 1992). In most western countries various co-ordinating strategies, such as; staff education and centralisation of referral and treatment records, have been employed within the penal system in an effort to address this system conflict. Reali and Shapland (1986) found, for example, that with education and communication between correctional staff and community mental health providers, the level of conflict seemed to notably decrease. Steadman (1992), in his review of co-ordination between the CJS and the mental health system, found that the use of "boundary spanners" improved co-ordination at the broader level. In NZ, an example of a "boundary spanner" is the court nurse, who is commonly deployed within the court room for the benefit of alleged offenders who may require MHS. This service has been found to increase the efficiency of treatment delivery for this category of offenders (Personal Communications; Court Nurse, 1994). However, while such efforts are a step in the right direction, there still appears to be an underlying degree of professional scepticism that is likely to continue to compromise system co-ordination in areas where these steps have not been implemented successfully.

The other major problem in this area is co-ordination between service providers. As previously highlighted there are multiple agencies involved in the provision of MHT for prisoners. The available literature suggests that there is a significant

deficiency in interagency co-ordination, which is likely to inhibit the provision of expedite treatment delivery (Casey et al., 1992; Grassy & Adams, 1994). With the current changes in the structure of the provision of MHS, there has been a growth in small specialist services. Manifestly, these small service agencies, both community and prison based, are faced with the difficult task of stream-lining the service and setting specific target groups for the provision of treatment. In conjunction with the reduction in resources, this appears to have created a fractionation of service provision (Bob Hudson, 1991). Targeting amenable treatment groups, setting treatment criterion, and prioritising the use of scarce resources are fundamental management issues. However, the primary objective of a MHS system is to cater for the needs of the service population. What appears to have eventuated as a result of specialisation in this area is an absence of adequate co-ordination between service providers to ensure that the population in question is adequately catered for (Keilitz & Roesch, 1992; Jemelka et al., 1993; Severson, 1992).

While the concept of specialisation has its merits, mental health problems can not necessarily be categorised that easily. For example, several clinical disorders such as; eating disorders and substance use disorder, may be exacerbated and /or precipitated by low self esteem issues and/or prior experience of various forms of abuse (Grob, 1991; Bob Hudson, 1991; Jones 1993). There are also persons with co-occurring disorders, who clearly require comprehensive care. For example, a reasonable number of psychotic patients have been found to have

superimposed anxiety disorders. Substance use disorder has also been found to be reasonable common in psychotic and depressed populations (Peters and Hills, 1993). The growth in specialisation appears to have reduced the emphasis on supply and demand in favour of treatment success. What this means is that there are likely to be a number of mentally disordered persons, MDP included, who do not meet the stringent treatment criterion of these specialist agencies (Pogrebin & Poole, 1987; Snow & Briar, 1990; Teplin & Pruett, 1992). Clearly, this is likely to inhibit service delivery for several mentally disordered persons, especially those with co-occurring disorders.

Policy and Prioritisation. As previously discussed, the provision of MHS is primarily governed by policy standards, which appear to cater adequately for the provision of a comprehensive MHS system. Nevertheless, when policy guidelines are perused more closely, it becomes apparent that chronicity is the primary emphasis for the provision of MHT within the bounds of humane containment. This pre-emphasis on chronicity is not uncommon across countries and jurisdictions alike. For example, it is stipulated under policy guidelines for the New York State MHS system, that the care of the chronically mentally ill in prison constitutes the fundamental objective (Dvoskin & Steadman, 1989; Green, 1988). Prins (1993) indicates that the emphasis is comparable in England, where psychiatric illnesses are commonly found to be the primary focus under policy for the provision of care. Hodgins (1988) reported that chronicity is also emphasised under policy in Canada. The situation is not dissimilar in NZ. Special reference is made regarding the

provision of treatment for severely MDP under the Penal Institutions Policy and Procedures Manual (1995) (Personal Communication; Superintentent of Paparua Prison, 1995). Given that MHS appear to be a scarce resource, this raises the concern that treatment for the chronically mentally ill may be the primary service available in real-terms.

As previously discussed, while the common policy objective is to provide a comprehensive service system, the most binding requirements are still the minimum legal standards of care. Cohen (1993) points out that these minimum standards constitute the baseline for the majority of treatment providers. In other words, with the limitation of resources, it is likely that service providers rely on these minimum requirement in the delivery of treatment. Dvoskin and Steadman's (1989) research supports Cohen's postulation. They found that this focus on chronicity, in conjunction with the scarcity of resources, has commonly produced a re-focus under policy, with the objective being the provision of a comprehensive MHS system of the chronically mentally ill rather than of MDP per se. Clearly, this is likely to seriously diminish MDP accessibility to treatment in real-terms. Given the limitation of resources, it is evident that these scarce resources must be prioritised in accord with the legal framework in question. The prioritisation of treatment delivery for chronically MDP is not disputed. However, the term chronicity is generally used to describe severe major mental disorders. It is clear that disorder severity, independent from disorder type, is a fundamental factor for the prioritisation of treatment delivery. Rogers and Webster (1989) have suggested

that treatability should be one of the primary factors involved in the prioritisation process. In accord with this view the provision of treatment for anxiety related disorders, for example, should be afforded reasonable priority as there are several cost efficient treatment options available that have notable success rates. While it is outside the bounds of this discussion, it should be noted that a significant proportion of psychotic patients have been found to have co-occurring anxiety issues, and it has been reported that the anxiety symptomatology has been found to be more debilitating than some positive psychotic symptoms.

As discussed in section 1.5, although there is an absence of empirical data, the information available suggests that mood and anxiety related disorders are likely to be common among prisoners. Unfortunately there is little agreement regarding the requirements for the provision of treatment for these types of mental health issues. As previously discussed, Zamble and Porporino (1988), for example, investigated the adjustment of inmates to the prison environment in Canadian penitentiaries (Bartol, 1991). It was found that symptoms of depression at admission naturally resolved upon adjusting to incarceration for a reasonable number of prisoners (Bartol, 1991; Rice & Harris, 1993). While some prisoners may adjust to the prison environment, Rice and Harris (1993) aptly point out that a certain percentage of prisoners are likely to develop a mood disorder that is not likely to dissipate without the provision of appropriate MHT. As already discussed in section 1.4, in accord with internationally recognised standards the provision of MHS

for humane containment relates to the well-being of the inmate and not solely to the issue of disorder type or severe. In other words, in accord with the principles of natural justice, the delivery of treatment for MDP with less salient disorders that fall within the bounds of humane containment principles is of equal importance as for the chronically mentally ill. With the current emphasis on chronicity rather than severity this means that prisoners with a severe mental disorder may not receive treatment if the nature of the disorder does not meet the chronicity criteria.

Crisis Intervention. Given the management problems discussed above, it comes as no surprise that there is growing concern that the main type of MHT offered on humane containment grounds is crisis intervention. While there is little empirical based research in this area, there is some descriptive research that indicates that this is likely be the case. The research conducted by Steadman et al (1989) evidenced that emergency treatment was the most prevalent form of treatment provided for MDO in custody at jail level. Findings by Reali and Shapland (1986) are in line with this, in that crisis treatment was found to be the most common form of treatment provided within the jail setting in their time of study. The situation appears to be similar in NZ. The working party (1981) reported that treatment for psychotic inmates was the most common treatment requested at remand level. As previously discussed however, while the provision of crisis intervention is acceptable as the main form of treatment offered at remand level, this is not deemed constitutional for mainstream prisoners (NZ Department

of Justice, 1981). Nevertheless it would appear that crisis intervention also functions as the primary form of treatment offered to MDP. Severson (1992) found in her review of the literature that generic and crisis based treatment progammes were the most prevalent MHS available for prisoners in the US. The NZ Department of Justice inquiry into prisons (1988) reported that there was growing concern expressed by mental health providers and correctional staff that crisis intervention is becoming the main form of MHT available for MDP in this country. As discussed earlier in this section the accessibility of inpatient care appears to be rather scarce for this population. The information available indicates that inpatient care is only available for crisis intervention. Verdun-Jones (1989) found that hospitalisation in the form of crisis intervention was the most prevalent form of inpatient treatment offered in the UK. The situation in the US appears to be similar. Greene (1988), for example, reported that due to the limitation of inpatient facilities, there is a considerable demand on outpatient treatment in the New York system. Similar findings have been reported by Dvoskin and Steadman (1989). This suggests that only those in crisis are likely to be offered inpatient or outpatient MHT. Although there is a dearth of NZ information in this regard, it has been suggested via certain government inquires that the situation in NZ is likely to be similar. In the Mason Report (1988), it was highlighted that there appeared to be a reduction in the use of hospitalisation, except for emergency/crisis based situations. Wardlaw (1983), in his review of the literature across western countries, found that crisis intervention, most notably in the form of medication, was

the most prevalent form of treatment offered. Rice and Harris (1993) also found that there is an over-reliance on medication in American prisons. The use of medication as a substitute for holistic care has been a concern raised by correction staff in this country (NZ Department of Justice, 1988). Without dismissing the benefits of medication, this indicates that drugs may be offered to those in crisis as a "quick fix". What this descriptive information indicates is that crisis intervention, mainly in the form of hospitalisation and medication, is likely to be the primary form of MHT offered to MDP.

Closing Comment. It is apparent that across western countries there are common generic difficulties involved in the provision of treatment for prisoners that are speculated to have brought the delivery of treatment to the minimum requirements of crisis intervention. The reduction of service availability within the community and the scarcity of such resources at the penal level, appear to be the most significant problem. Clearly, low resources inhibits service availability. However, this factor also appears to be integral to the other problems found in this area. Specialisation of services, in conjunction with stringent treatment criterion and prioritisation of treatment delivery, all relate in part to resource limitation and are likely to diminish certain MDP's chances of treatment provision. Resource reduction also appears to be a factor in the emphasis placed on chronicity under policy. While this complies with the minimum standards required, it does not comply with the policy objective of a comprehensive MHS system. It is the ambiguity found in the legal framework that allows the minimum standards to function

as the fundamental legal requirement. The ambiguity in this area could also account for the co-ordination problems found within and between systems. Manifestly, as found with the identification system, most of the difficulties in this system appear to be integral to the equivocality of the legal framework.

The available literature indicates that the provision of treatment for MDP functions at the base-line of crisis intervention. Limiting treatment for prisoners in crisis means that many MDP who are entitled to access to MHS are not likely to be offered treatment. In other words, the delivery rate of MHT for MDP is likely to be quite low. Moreover, it would appear that the scarcity of MHS has shifted the policy focus to the basic legal requirements. This information suggests that crisis intervention for the chronically mentally ill is likely to be the most prevalent form of MHT available for MDP in real-terms. This raises the question as to what factors come into play in the delivery of treatment.

1.7.4. FACTORS PREDICTED TO INFLUENCE TREATMENT DELIVERY.

Given the evidence elucidated thus far, it is apparent that the services prisoners technically have access to are not necessarily available at the practical level. Moreover, the current situation of significant resource limitation suggests that treatment delivery may well be limited to crisis intervention for MDP. Manifestly, the final matter of interest is what factors appear to precipitate the provision of MHT. In other words, who is the most likely to be offered treatment in the prison setting. Unfortunately, the majority of the literature has attended to the issue of service availability rather than

treatment delivery per se. What this means is that, yet again, there is sparse empirical research that has investigated this important issue. Nevertheless, some insight into this process can be obtained from the available literature.

As highlighted in the previous sub-section, the major focus in this regard has be the provision of services for severely MDP. Across countries services for chronically and acutely MDP are the most commonly available, largely relating to the minimum legal requirements. What this means is that prisoners who exhibit disorders that fall within these bounds are more likely to be offered treatment. In other words, this suggests that the nature and severity of a current disorder are likely to be related to be practical delivery of treatment. There are research findings that concur with this descriptive based information. In Teplin's (1990) research, as referred to in section 1.6, the operational definition of detection was a referral for treatment and/or treatment offered. Therefore, her findings also shed some light on the treatment delivery process. Pertinent to this discussion is that Teplin found that inmates with schizophrenia were more likely to be offered treatment than whose with major depression. Findings obtained by Dell and Smith (1983), in their research investigating the usage of hospital orders for offenders in Britain, are in line with Teplin's results. Dell and Smith found that the presence of schizophrenia was the most significant factor in the sentence of a hospital order as opposed to imprisonment, for offenders charged with homicide and ruled to have diminished responsibility. Aubrey's (1988) research findings are also consistent with the above results. He found

that 41.1% (n = 101) of the jail detainees sent for a competency evaluation were diagnosed with schizophrenia. What these findings indicate is that the presence of severe overt symptomatology is likely to increase the delivery of treatment. This indicates that the nature and severity of a current mental disorder are indeed likely to be critical factors in the delivery of treatment.

It is widely speculated that mental health history recorded on file is positively related to the provision of MHT. There is little direct research evidence available regarding the delivery of MHT for MDP. However, this factor does appear to influence the delivery of treatment at other levels in the CJP. The most common emphasis regarding mental health history is past hospitalisation, which frequently necessitates the presence of a severe/overt disorder. Nevertheless, the provision of outpatient treatment is often found to be recorded. This information is likely to increase the delivery of treatment from the community mainly because these offenders are already within the mental health system and otherwise because it is likely to increase prioritisation. Aubrey (1988) found mental health history to be a very influential factor. He found that 55% of the persons assessed had a history of inpatient treatment and a further 20% had a history of outpatient treatment recorded, whereas only 2% of the control group had past outpatient treatment recorded. Dell and Smith (1983) found that previous psychiatric treatment increased the chance of hospitalisation over imprisonment. Teplin (1990) also found in her research that mental health history was an extremely robust predictor, stronger in fact than

current mental health status. More directly, Hochstedler (1986) found that MDP had a higher chance of receiving inpatient care with a record of past hospitalisation. What this indicates is that in accord with the detection process, mental health history recorded on file is likely to influence the chance of treatment being offered to MDP.

While disruptiveness appears to be significant in the likelihood of detection, there are inconsistent findings relating to this factor's influence in treatment delivery. As discussed in section 1.6, Toch and Adams (1988) found that disruptiveness commonly elicited a referral for apparently disturbed inmates. Teplin's (1990) finding that a higher rate of inmates with schizophrenia were detected/offered treatment than those with major depression, also suggests that disruptiveness is involved in treatment delivery. More directly, Adams (1986) found that disruptiveness in prison related to treatment offered. Hodgins (1988) and Rice and Harris (1993) also concluded from their reviews of treatment provision that disruptiveness is likely to be a significant factor in treatment delivery. What this suggests is that disruptiveness is involved in the prioritisation process within the treatment delivery system. Porporino and Motiuk (1995) referred to research conducted by Toch and Adams (1989) which supports this notion. In their research they found that inmates with more and/or longer episodes of disruptiveness had a higher likelihood of being offered treatment. However, these above findings are inconsistent with the general literature in this area. It has constantly been reported across countries that mental health providers have

significant reservation in providing disruptive-disturbed prisoners with inpatient care, especially within community based facilities (Adams, 1986; Bartol, 1991; Morrissey & Goldman, 1986; NZ Department of Justice, 1981; 1988; NZ Ministry of Health, 1987; Prins, 1993; Wardlaw, 1983). Teplin and Pruett (1992), for example, found that at arrest level disruptiveness had a negative influence on treatment offered. This indicates that there is some resistance in providing this category of MDO treatment, which suggests that disruptive MDP may not be offered treatment unless crisis intervention is required. What this means is that while disruptiveness appears to influence detection it may not directly relate to the provision of treatment.

As discussed in section 1.6, personality traits may be involved in the detection process. The same may also be found in the treatment delivery system. The TCI literature discussed in section 1.6, is also relevant here. To recap, there is research evidence obtained via the use of the TCI that indicates that symptom manifestation may be influenced by personality type. It is well established via descriptive based research that the provision of treatment for MDO with personality disorders is quite low. A lengthy review of the possible reasons for this is not pertinent to this discussion. The point at hand is that treatability of personality disorders is a controversy issue and that the relationship between personality disorders and crime itself, especially regarding the diagnosis of antisocial personality disorder, is subject to debate (NZ Department of Justice, 1981; NZ Ministry of Health, 1984; 1987; Peay, 1988).

In other words, it is likely that treatment delivery is low based on the assumption that polarised maladaptive traits or personality disorders are at least difficult to treat and/or that some such disorders at least appear to be related to criminal behaviour. This indicates that it is not unlikely that mental health providers rely, in part, on personality traits in the selection process for the provision of treatment in relation to the probability of treatability and treatment success.

Belfrage (1991) found in her research, that treatment success (measured via recidivism rates) for MDO was related to the type of treatment utilised and the nature of the current offence. Similar findings have been found regarding certain types of rehabilitative treatment interventions and certain categories of offenders, based on crime type (Bakker & Riley, In Press; McLaren, 1992). What this indicates is that selectivity in treatment groups and the type of treatment provided are involved in the treatment delivery process. Clearly, personality traits may be involved in this selection process. Rogers and Webster's (1989) review of the literature supports this notion. They reported that personality traits do appear to be involved in treatment success. Ashford (1988), for example, found that personality characteristics were one of the strongest factors involved in treatment recommendations. More specifically, the research conducted by Hodgins and Côté (1993) and referred to in section 1.6, is equally relevant to the treatment delivery system. To recap, the pertinent finding was that mentally disordered inmates without APD stood out from mentally disordered inmates with ADP, and non-mentally disordered

inmates with and without ADP. This suggests that mentally disordered inmates with atypical "criminal" personality traits may be more likely to be offered treatment than mentally disordered inmates who exhibit "normal" criminal characteristics.

Again, as discussed in section 1.6., it is likely that substance use comorbidity issues may come into play in the treatment delivery process. While mental health providers are naturally more aware of the common relationship between mental illness and substance use in the form of self-medication, this factor still appears to be more likely to decrease the chance of being offered MHT. First, in line with the detection process, there is the fact that substance use issues may be viewed as a typical criminal characteristic, thereby reducing the likelihood of the offer of MHT. Secondly, there is research evidence that indicates that the presence of multiple mental health problems, especially substance use comorbidity, reduces the likelihood of the provision of treatment in the community, due to the stringent admission criteria found across mental health agencies (Freeman & Roesch, 1989; Pogrebin & Poole, 1987). As previously discussed, Peters and Hills (1993), found that MDP with alcohol and drug issue had limited access to MHT due to the lack of treatment programmes available that catered for this extremely vulnerable group. Therefore it is likely that substance use comorbidity issue may decrease the chance of being offered MHT.

Closing Comment. Clearly, what comes through the available literature is that the factors that appear to have the most

influence on detection are also equally likely to have a significant bearing on the delivery of treatment, except for disruptiveness. This similarity is not surprising given that there should be a positive relationship between the detection/ referral process and the treatment delivery system. Given the lack of empirical research in this area it is somewhat difficult to ascertain the degree of influence these factors may have on treatment delivery, distinct from the relationship found at detection level. However, as noted in section 1.4, a referral is not necessarily matched with the provision of treatment, as treatment delivery is an independent system. What this means is that these variables may influence the likelihood of treatment delivery independently from the detection process.

1.7.5. SECTION SUMMARY.

With this more detailed perusal of the legal requirements for the provision of MHS it is apparent that these are more definite than the legal requirements for the identification process and that the requirements under NZ law are in accord with internationally set standards. In line with other western countries, however, the legal requirements still constitute minimum standards of care. It is evident that the policy guidelines that have been set to bridge the gap between minimum standards and the provision of a comprehensive MHS system lack legal clarity in the nature of the services required to fulfil this policy objective. The examination of the services technically available to prisoners across countries, shows that there is commonly a variety of services available from the community and penal based agencies. While this is indicative of

a comprehensive service system, when accessibility is perused in more detail it is clear that the provision of MHS for this offender population is sparse in relation to the demand. It is evidenced in the literature that, while the provision of rehabilitative MHS is unlikely to meet the demand, this type of treatment appears to be more accessible than humane containment based MHT. The literature indicates that the rate of treatment delivery for MDP is exceptionally low whereby *crisis intervention* appears to be the primary form of MHT offered. The main factors that appear to account for this base-line approach to the provision of essential resources are; narrowly focused policy objectives and prioritisation criteria, system and service conflict and co-ordination problems, and mostly significantly, resource limitation. The sparse research in this area indicates that crisis based MHT primarily constitutes the provision of medication for acutely and chronically ill inmates or hospitalisation/inpatient care, which is reportedly quite rare in relation to the demand. Clearly this is an unacceptable level of service provision, where even severely disordered inmates are found to have a low chance of receiving essential MHT. In perusing the literature to ascertain what factors may increase a MDP' chance of being offered MHT, the research indicates that; the nature and severity of a current disorder, past mental health problems on file, and personality traits, are likely to have the most influence on treatment delivery. Again, it is apparent that there is an urgent need for comprehensive research regarding the actually delivery of MHT for MDP, given the dearth of empirical research addressing this important aspect of the provision of MHS.

1.8. AN INCREASE OF MDO IN PENAL CUSTODY.

What has been established in the preceding two sections is that MDP's access to MHT is likely to be limited. This means that MDP appear to be a significantly vulnerable group to human rights infringements, which is a serious issue in and of itself. When the broader social context is taken into consideration, however, the urgency of this issue becomes more apparent. The current social attitude toward offenders and the changes in the mental health system have had an impact not only on the prison population. There has been a clear interactive effect between the changes within the CJS and within the mental health system, which seem to have increased the likelihood of MDO being incarcerated. Given that this is guaranteed to place more pressure on an apparently under-developed network of systems within the prison system and is also likely to place MDP at further risk of human rights infringements, it is important briefly to peruse the literature in this area. Therefore what follows is; a synopsis of these system changes, a brief summary of the pertinent research in this area and the implication of the research findings.

1.8.1. CHANGES WITHIN THE MENTAL HEALTH SYSTEM.

Deinstitutionalisation and Community Care. The post World War II societal introspection and growth of moral consciousness had a significant impact on the mental health system. Across most western countries, mental asylums have experienced a history similar to penal institutions, in that such issues as; hygiene, overcrowding, the treatment of patients and long periods of detention, were questioned on humanitarian grounds. The increased support for the humanitarian and civil libertarian

movements during this time heightened public awareness of the poor standards of treatment for institutionalised mentally disordered persons, which brought substantial public pressure on the state to re-evaluate the societal management of this social group (Durham, 1989; Grob, 1991; Haines & Abbott,1985; Bob Hudson, 1991; Jones, 1993; Menuck & Fleming, 1993; Morrissey & Goldman, 1986; Salzberg, 1991; 1992). This heightened moral concern coincided with natural changes within the field of mental health. There have been significant shifts away from the early medical model of mental illness to the more holistic contemporary biopsychosocial approach to mental health. In conjunction with changing social attitudes, these doctrine changes have broadened the population that mental health providers cater for and have also increased the availability of treatment options, most notably the utilisation of psychotropic medication. The success of psychotropic medication brought a reduction in the demand for inpatient care, while the general improvements in treatment options, increased the demand for outpatient services (Bartol, 1991; Disley, 1990; Durham, 1989; Grob, 1991; Haines & Abbott, 1985; Bob Hudson, 1991; Jones, 1993; Morrissey & Goldman, 1986). In several western countries these events paved the way for the endorsement of the twin policy for deinstitutionalisation and community care (Disley, 1990; Durham, 1989; Haines & Abbott, 1985; Bob Hudson, 1991; Morrissey & Goldman, 1986; Stacey, 1988). While this twin policy was implemented in England and the United States in the 1960's, the official endorsement of deinstitutionalisation only became clear in NZ by the late 1980s. However, the move toward community care and away from institutionalisation was in

silent process from the early 1970s despite opposition to this shift (Dowland & McKinlay, 1986; Haines & Abbott,1985). From the perspective of mental health providers and human rights activists alike, the aim of this twin policy was to reduce the use of institutionalisation and to advance the quality of care provided for mentally disordered persons in the community for the protection of such persons' rights (Durham,1989; Haines & Abbott,1985; Bob Hudson,1991).

Mental Health Legislation. Juxtaposed to policy changes in the mental health system there have been associated amendments within the relevant legislation, in several countries. The primary issue of concern has been the degree of coercive intervention permitted within the legislation (Dawson, 1984). In several countries, what became apparent was that mentally disordered persons had little legal protection. In other words, such persons' human and civil rights were poorly protected under the available legislation, making this social group extremely vulnerable to rights infringements (Brody, 1988; Brunton, 1985; Dawson, 1984; Durham, 1989; Grob, 1991; Haines & Abbott, 1985; Jones, 1993). The discretionary power afforded to "hospital authorities" and the legal framework depicting; the commitment criteria, the compulsory treatment option and the release conditions, have been the major points of contention. Clearly, involuntary commitment is a serious encroachment on persons' right to liberty. In relation to this, the provision of long-term inpatient care has also been scrutinised, given the apparent adverse affect of institutionalisation (Durham, 1989; Haines & Abbott, 1985; Bob Hudson, 1991; NZ Ministry of Health,

1987). Patients' right to refuse treatment has also widely been viewed as an essential legal requirement given the intrusiveness of certain treatment options available (Grob, 1991; Jones, 1993; NZ Ministry of Health, 1987). Subsequently, across several countries, the internationally recognised principle that the state should utilise the "least restrictive option" for the fulfilment of legitimate governmental aims, was widely argued to have equal importance in the management of mentally disordered persons as it should for offenders (Dawson, 1984).

Manifestly, there was significant pressure placed on the state, across several countries, to enforce a legalistic model of rights to provide better legal safeguards to protect this vulnerable group, especially regarding the right to liberty (Aviram, 1990). As a result of pressure for legal reform regarding these somewhat controversy issues, there has been a general trend found across countries and jurisdictions to limit the discretionary power of "hospital authorities" via the implementation of more stringent criteria for; commitment, the provision of compulsory treatment and release conditions (Brunton,1985; Haines & Abbott,1985; Morrissey & Goldman,1986; Stacey,1988; Grob,1991; White,1989; Jones,1993). While amendments in legislation in this line were implemented in England and the United States in the 1970's, other countries such as; Japan, Israel, Scandinavia, and Taiwan, did not introduce significant legislative changes until the late 1980s to the early 1990s (Durham, 1989; Levy, 1992; Salzberg, 1991; 1992; Vestergaard, 1994). Similar changes in NZ law were not introduced until the early 1990's. The NZ Mental Health

Act 1992, is clearly aimed at restricting admissions to psychiatric facilities and reducing the length of stay for inpatient care. For example, under this Act, the commitment criteria focuses on the issue of dangerousness (to oneself or others) rather than solely on disorder severity.

The Outcome of these Changes. In several western countries, including NZ, there has been growing support for the view that the implementation of this twin policy and the associated legislative changes may actually serve to further disadvantage this vulnerable social group. Clearly, the specialisation of service provisions and the de-emphasis on institutional care are integral to this twin policy, which means more funding is required within the community to cater for the increase in demand, and that proficient service co-ordination is essential for continuity in the provision of quality care. Kemp (1990) and Bob Hudson (1991) have pointed out that the quality of these factors is pivotal to the success or failure of a community based MHS system. Hoult (1985), for example, describes the success of a pilot programme of community care in Australia. Stacey (1988) also provides an example of a comparatively successful transition in England from hospital care to community based care, with the impending closure of the hospital. However, it is clear that the key to the success in these two incidents is that both projects were well funded and thorough planning and co-ordination was involved. It would appear that these examples are exceptions to the rule. In most western countries it is commonly reported that there are significant problems in obtaining promised funding and there is deficient service co-

ordination within the current mental health system. These factors have been related to a decline in the deployment of qualified mental health staff and the fragmentation of services. The premature closure of hospitals has also been viewed as a major contributing factor in the failure of deinstitutionalisation. A common policy recommendation found across countries has been that hospital closure should not precede the establishment of alternative service provisions. However, hospital closure has not significantly been delayed in light of the apparent system difficulties (Durham, 1989; Grob, 1991; Bob Hudson, 1991; Jones, 1993; Kemp, 1990; Reali & Shapland, 1986). As highlighted earlier, in several western countries, there is now a serious limitation in bed capacity, where the majority of psychiatric hospitals often have lengthy waiting lists (Durham, 1989; Bob Hudson, 1991; Morrissey & Goldman,1986). Although this twin policy has not been in action in this country for as long as that found in others, it is apparent that the situation in NZ is still comparable. In the last ten years five[19] psychiatric hospitals have been closed in NZ (Personal Communications; Ministry of Health, 1995) and the lack of community funding is also evident (Christchurch "Press" 28/2/94). While hospital closures have placed more demand on residential and non-residential service providers, some small voluntary based community support services have also closed due to the lack of funding (Personal Communications: Homeless Women's Shelter, 1995). As Durham (1989) and Haines and Abbott (1985) have pointed out, the perversity of the current situation is that an increase in demand for services has

[19]Carrington, Oakley, Raventhorpe, Lake Alice and Cherry Farm.

coincided with a reduction in service provisions, placing further pressure on a diminishing system.

The major concern regarding legislative changes has been the emphasis placed on the "legalistic model" of rights, in that the focus of the legal framework is primarily on negative rights rather than treatment needs (Aviram, 1990; Greenberg & Bailey, 1994; Miller, 1992). While mentally disordered persons' right to liberty is an imperative consideration, there is still a need for institutional services within the community. For example, behaviours such as; failure to keep appointments, treatment non-compliance and "self-medication", are reasonably common for certain sub-groups of this population (Belcher, 1988; Freeman & Roesch, 1989). Manifestly, institutionalised care may well be the most appropriate treatment option. However, admission for inpatient care, especially via the committal process, commonly relates to dangerousness (to oneself or others) rather than treatment requirements (Aviram, 1990; Freeman & Roesch, 1989). This means that mentally disordered persons who require inpatient care but who are not considered; dangerous, treatment compliant or "treatable", are less likely to have adequate access to this type of treatment (Peay, 1988). Slovenko (1989) claims that there is a clear absence of *common sense* within this legal framework. While the deprivation of liberty is a serious imposition and the discretionary powers of "hospital authorities" should be kept to a minimum, the fundamental rationale for the provision of inpatient services is *treatment delivery* not public safety.

More Mentally Disordered Persons in the Community. With hospital closures and more stringent admission/commitment and release criteria, it is evident that there is a related increase in the number of mentally disordered persons residing in the community. In the US, for example, the bed capacity of the state hospitals was reduced from 550 000 in 1961 to 110 000 by 1975. Holley and Arboleda-Florez (1988) reported that in Canada, 34 000 patients were discharged between the period of 1961 and 1976, and that comparable reductions have also been reported in England. Clearly, the situation in NZ is no different given the hospital closures and legislative changes. In NZ, in line with other western countries, not only is there a reduction in bed capacity which limits admission options, there is a reduction in the average length of stay for patients and readmissions proportionately outweigh first admissions (Freeman & Roesch, 1989; Bob Hudson, 1991; NZ Ministry of Health, 1993). What this means is that there is a substantial number of ex-patients who now reside within the community and that there is also a growing number of mentally disordered persons within the community, who would have been hospitalised pre-deinstitutionalisation. While this sounds good in theory, as discussed above, there is a significant lack of funding for community based mental health facilities. What this means is that ex-patients and "would be" new patients or the non-institutionalised are reliant on a skeletal community based mental health system which has difficulty catering for the population it is designed to serve (Freeman & Roesch, 1989; Bob Hudson, 1991; Prins, 1993). Clearly, there is considerable concern regarding how this group of people is coping within the

community. While it would appear that many mentally disordered persons can manage outside the walls of mental asylums, for some this is only possible if there is a comprehensive community system, which requires more funding than is made available at present.

Closing Comment. While this has been a brief perusal of the changes in the mental health system, it is apparent that the implementation of this twin policy and the associated legislative changes have not had the desired impact on the lives of mentally disordered persons across western countries. It would appear that, in contrast to the aim of improving the quality of care and the protection of rights, the poor implementation of these system changes has set the stage to further disadvantage this vulnerable social group. While the repercussions are not as pronounced in this country, due to the time difference in the implementation of these changes, it is clear that the outcome thus far is in line with other western countries. What this means is that the fate of these vulnerable individuals, especially deinstitutionalised and non-institutionalised "patients", is an equally pressuring issue in this country as found elsewhere.

1.8.2. THE AVAILABILITY OF DIVERSION OPTIONS WITHIN THE CJS.

It has historically been acknowledged that mentally disordered persons can and do come into contact with the CJS. As previously highlighted, the *parens patriae* function of the state can be exercised via the CJS. Subsequently there have historically been diversion options available for mentally disordered persons throughout the CJP. This is primarily because it is considered

"unjust" to punish such persons (Baker, 1993). The insanity plea, the plea of unfit to plead, the availability of a transfer for inmates, and the ability of the police to divert mentally disordered persons under their *parens patriae* function, constitute the primary and the longest standing options which are still available today. It is important to note, that with the previously mentioned changes within the CJS, there has been an increase in diversion options for MHT over time. While the original diversion options, which are the most pertinent to this discussion, are founded on humanitarian grounds and the principles of fair play, additional options mostly relate to the provision of rehabilitative MHT and are founded on the "last resort" principle in conjunction with rehabilitative policy objectives. What this means is that MDO and non-MDO may be deemed eligible for diversion for rehabilitative MHT.

Surrounding Controversy. Although certain diversion options have historically been available, this is not to say that the availability of these options has been without controversy. While a lengthy discussion regarding the controversy in this area is not pertinent, it is important to highlight the fundamental issues involved in this complex matter. As discussed in section 1.4., MDP access to MHT constitutes an important human right in accord with the fundamental premise of natural justice. The same is true throughout the CJP. For example, in accord with the moral concept of natural law and the principles of fair play, it is considered unconstitutional to try a person actively unable to partake in the judicial proceedings or to punish a person unable to understand the "wrongness" of the offence committed, due to such person's mental health status. Although there is this moral desire not to

punish a mentally disordered person, there is still the fundamental need to punish offenders in the name of justice. Not surprisingly then, there has long been public scepticism regarding offenders' motivation to pursue such diversion options (Baker, 1993, Prins, 1980; 1993; Sherlock, 1985). Additional diversion options for MHT, made available under rehabilitative objectives, have also been meet with similar scepticism (Rogers & Bagby, 1992). Several issues have become the subject of debate, such as; the validity of the relevant pleas and diversion options, the reliability of clinical judgements, the definitional boundaries used to determine the relevancy of offenders' mental health status, such offenders subsequent eligibility for diversion options, and the definition of culpability (Bartholomew, 1981; Jackson, 1986, Kopelman, 1990; Prins, 1980). The pivotal point of the controversy, however, is the issue of criminal responsibility which fundamentally relates to the insanity plea. The insanity plea is the primary avenue available that specifically addresses the issue of an offenders' criminal responsibility and thus culpability, on the basis of the offender's mental health status. There has long been public scepticism regarding offenders' motivation to pursue this option, mainly because the usage of the insanity defence has historically been associated with serious offences. This association has brought considerable scepticism regarding the validity of this plea and whether any mental health issues can render a person not criminally responsible (Barbara Hudson, 1987; Kopeland, 1990; Prins, 1980).

The introduction of further diversion options under rehabilitative grounds has added to the controversy. As discussed in previous

sections, the court is duty bound to impose a disposition that is most likely to reduce recidivism and that is the least restrictive in nature. It is these factors that primarily determine offenders' eligibility for such diversion options. Offenders' access to diversion options is most commonly at pre-trial, mainly in the aim of avoiding the expense of court time (Cooke, 1989; Roesch et al., 1995). However, such options are also available at trial, sentencing and post-sentencing levels. Factors such as a mental health evaluation and personal case history, for example, are commonly admissible to the court as mitigating factors allowing for the courts utilisation of its discretionary power regarding the imposition of diversion away from punitive sanctions. Clearly, the imposition of MHT for rehabilitative purposes is viewed by some social factions as a "soft option" compared to more standard penal sanctions and is therefore subject to scrutiny. However, because mental health issues can commonly be introduced at sentencing as mitigating factors for the provision of rehabilitative MHT, the availability of such options have come under readdress on the grounds that these options erroneously relate to the issue of culpability and thus criminal responsibility. In other words, the point of contention in this regard is that "mental health problems" introduced at sentencing can have a bearing on the sentence imposed which suggests that such issues are associated with criminal responsibility, which contravenes the founding principles of the legal system (Barbara Hudson, 1987; Kopeland, 1990; Prins, 1980; Verdun-Jones, 1989).

In several western countries various attempts have been made over time to practically address the controversy in this area. In the US,

for example, the Durham rule, then the Brawner rule and later the Currens rule, were introduced into American law due to discomfort with the M'Naghten rule, which constitutes the first guidelines documented for the insanity defence (Baker, 1993; Bartol, 1991, Faed, 1992; Freeman & Roesch, 1989; The Law Reform of Western Australia, 1987). The fundamental purpose of these additional modes of what constitutes "criminal responsibility", or more appropriately the lack of the same, was to provide a more precise definition of insanity per se. However, it is via these rules that concepts such as; capacity of control, partial responsibility and impulsiveness, have been introduced into the courtroom, which has simply produced further confusion regarding the issue of criminal responsibility and has added to the ongoing controversy. In Canada there have been changes made to the M'Naghten rule and further changes to the "insanity plea" (Hodgins, 1988; Verdun-Jones, 1994). While there have not been major changes in NZ or Australia in this regard, there has still been comparable controversy relating to the validity of the insanity plea. In Australia, for example, the US Currens rule was reviewed for its potential in the Australian legal system (The Law Reform of Western Australia, 1987). In NZ there have been cyclic legislation changes shifting the responsibility of such "offenders" to and from the CJS and mental health system, which is indicative of the societal discomfort with this doubly deviant group (Brunton, 1985; Faed, 1992). The situation in England, however, is not very dissimilar from that in the US. The Homicide Act 1957, was introduced in England and allowed for the plea of diminished responsibility on the grounds of "abnormality of the mind" (Bartol, 1991, Prins 1993). While the passing of this Act reduced the use of the insanity plea, the term

"diminished responsibility" has brought its own problems into the courtroom, comparable to the difficulties the Brawner rule poses in the US.

The Current Social Context. There has historically been a certain degree of discretionary power available for all diversion options throughout the CJP. The socio-political climate can largely interface with the CJP in this regard. The contemporary public attitude toward offenders and mentally disordered persons is likely to have a bearing on the current usage of diversion options. As previously discussed, with the current level of crime in the community, especially violent crime, there is a considerable degree of public disquiet regarding the low level of public safety which is reflected in the social pressure for more restrictive penal sanctions. This current social attitude toward offenders has brought with it renewed social scepticism regarding offenders' motivation to seek diversion options and the validity of the inquiry into the mental health status of offenders (Prins, 1980; 1993; Rogers & Bagby, 1992; Verdun-Jones, 1989). The reduction in mental health services in the community, especially inpatient care, has also added to the social concern regarding the utilisation of diversion options. As highlighted previously, the boundaries defining mental disorders and the social attitude toward mentally disordered persons have changed/broadened over the years. However, while there has been a significant humanitarian shift which acknowledges the rights of mentally disordered persons, this is not to say that the public view has altered that dramatically over time (White, 1989). Mentally disordered persons are still commonly been viewed with an element of distrust. Due

to the very nature of certain mental disorders, especially when untreated, some mentally disordered persons can exhibit quite bizarre and inappropriate behaviour that induces this public fear (Freeman & Roesch, 1989). Research by Howells (1984) and by Kropp et al (1989), which were referred to in section 1.6., highlight this view. To recap, it was found in both studies that MDO were viewed as unpredictable and more dangerous than mainstream offenders. Moreover, as discussed previously, there has long been the association between mental illness and violence, mainly because of the relationship between violent crimes and the use of the insanity defence, which further contributes to the public fear of mentally disordered persons and the social discord regarding the use of diversion options. This public perception is reinforced by media polarisation of serious offences committed by mentally disordered persons (Faed, 1992; Freeman & Roesch, 1989; Høyer, 1988; Porporino & Motiuk, 1995).

It is important to note that, while some violent crimes are committed by mentally disordered persons, the majority of violent crime is not. Moreover, the insanity plea is seldom sought and most people who enter this plea are not successful (Philips, Wolf, & Coons, 1988). It must also be acknowledged that one major civil/human rights issue is that MDO who are deferred to the mental health system are likely to be detained in hospital for a longer period than such persons would be likely to spend in prison had they been sentenced for the offence in question (Hodgins & Gaston, 1989; NZ Ministry of Health, 1987; Peay, 1988; Toch & Adams, 1989). However, these facts appear to have little impact on the social attitude toward "MDO", especially in the current

social climate. The primary function of the early mental asylums was the provision of public safety which reflected the social fear or "distrust" of the mentally ill (Brody, 1988; Reali & Shapland, 1986). The desire for public safety in this regard still prevails today. However, with more mentally disordered persons in the community, a high level of violent crime, a reduction of inpatient facilities, and mental health legislative changes, there is a considerable degree of concern regarding the public safety measures available to protect the community from MDO and mentally disordered persons alike. The primary public concern is that MDO may be erroneously released back in the community by the court due to the lack of hospital space or prematurely released from hospital due to the more stringent commitment and release conditions commonly in place. This is highlighted in this country by the public outcry regarding the hospital release of certain MDO back into the community (Christchurch "Press", 24/1/94; 10/12/94). What this means is that there is a high demand for public safety measures for the protection of the community from mentally disordered persons and MDO in a social context where there is diminished mental health resource, which is likely to influence the availability and usage of diversion options.

Closing Comment. This brief overview of the availability of diversion options and the related controversy, highlights that there has long been social discord as to what constitutes an appropriate course of action for mentally disordered persons who meet with the CJS. It is clear that the contemporary socio-political climate and social context has renewed this social discourse and is likely to have a significant impact on the availability and use of

diversion options within the CJS. Not only is there pressure on the CJS to provide better public safety measures regarding the offender population but there is also considerable pressure on this social system to improve the provision of public safety from mentally disordered persons. With this high demand for better safety measures and the scarcity of mental health resources, especially inpatient facilities, there is growing concern that mentally disordered persons who meet with the CJS are more likely to be detained in penal custody.

1.8.3. MORE MENTALLY DISORDERED PERSONS IN JAILS.

Increase of Mentally Disordered meeting with the CJS. There has been raised concern that more mentally disordered persons are likely to come into contact with the CJS due to the increase of such persons residing in the community and changes in the mental health system. The first issue is whether there appears to be an increase of mentally disordered persons coming into police contact post-deinstitutionalisation. Durham (1989) concluded in her review of the literature that there is an absolute increase in the number of mentally ill coming into police contact. This concurs with Pogrebin and Poole's (1987) findings in their review of the research in this area. Bonovitz and Bonovitz (1981), for example, found that between 1975 and 1979 in one state in the US there was an estimated increase of around 200 percent in the number of mental health incidents that came to the attention of law enforcement officials. Pogrebin and Poole concluded that there appears to be a direct relationship between the deinstitutionalisation process and the apparent increase of mentally disordered meeting with the police. While the majority

of the research in this area is US based, it is commonly assumed across western countries that with an increase of mentally disordered persons within the community more mentally disordered persons are likely to be involved in the CJP (Bartol, 1991; Freeman & Roesch, 1989; NZ Department of Justice, 1988). In NZ there is no direct research evidence in this regard, however, there is still some indication that the police are likely to have more dealings with mentally disordered persons following the implementation of deinstitutionalisation measures. With the introduction of the Mental Health Act 1992, for example, the NZ police were issued with a revised version of the police module for dealing with mentally disordered persons. The main purpose of this new module was to familiarise the police with the new legislation and prepare the officers for more involvement with the mentally ill (NZ Police Training Development Section, 1992). This indicates that in line with other western countries, there is an expectation that more mentally disordered persons will come into contact with the police as a result of system changes.

Increase in the arrest rate of the Mentally Disordered. The second issue that has been addressed is whether there is an increase of arrest post-deinstitutionalisation. The majority of the research investigating this issue has concentrated on the arrest rates of mentally disordered patients and arrests for misdemeanours. McFarland, Faulkner, Bloom, Hallaux and Bray (1989), conducted a survey investigating this issue in the US. It was found that 52% (n = 260) of the mentally ill subjects had been arrested at some point in time with an average of 3.3 arrests. The authors calculated a standardised arrest rate of 28% for their sample, which was found

to be significantly higher than self-reported rates (17%) for the western states. Schellenberg et al (1992) reviewed the literature on arrest rates of mentally disordered patients and the findings of McFarland et al (1989) are congruent with other investigations. Sosowske (1980), for example, collected data on the arrest rates of 301 psychiatric patients after hospital release, which revealed that 41% were arrested. Compared to the annual arrest rate per 100, 000 for the San Mateo County general population, the arrest rate of ex-patients was five times higher. Schellenberg et al (1992) found that higher arrest rates of mentally disordered patients than the general population was not uncommon in the research perused, however, results did vary. Rabkin (1979) undertook research in this area to ascertain if there is a tenable difference in the arrest rate of mentally disordered persons post and pre-deinstitutionalisation in the US. She found that pre-deinstitutionalisation (pre-1965) the arrest rate of patients was lower than the general population whereas patients post-deinstitutionalisation (between 1965 and 1979) were found to have an arrest rate equal to or greater than the general population. Schellenberg et al (1992) concluded from their review that the research evidence available largely concurs with this finding. The majority of this type of research has been US and Canadian based. However, these findings are likely to apply to other western countries where deinstitutionalisation policy has been implemented. While research in NZ is sparse, concern has been expressed in departmental inquires that the impact of deinstitutionalisation is likely to emulate other western countries (NZ Department of Justice, 1988; NZ Ministry of Health, 1987). Therefore, what these findings indicate is that, in western

countries where this mental health twin policy has been implemented, there appears to be a higher risk of arrest for mentally disordered persons who come into contact with the CJS post-deinstitutionalisation.

This risk of arrest has brought researchers' attention to the dynamics involved in police contact with mentally disordered persons. Schellenberg et al (1992) reported that in a few studies reviewed it was found that a significant proportion of the mentally disordered participants were arrested for trivial or nuisance offences. Schuerman and Kobrin (1984) found in their patient study, for example, that 75% of all arrests were for misdemeanours. Research findings by Axelson and Wahl (1992) are congruent with such findings. Axelson and Wahl found that a significantly higher proportion of psychotic offenders were charged with *minor* misdemeanours than non-disordered offenders or non-psychotic but disordered offenders, who were also charged with misdemeanours. What these findings indicate is that such persons are being arrested for offences that may have been "overlooked" in the pre-deinstitutionalisation era. Clearly this brings to question why the police tend to be opting for this course of action. Pogrebin and Poole (1987) reviewed the literature in this area. Lamb (1982) found, for example, that police were more likely to arrest mentally disordered persons rather than refer to hospital due to such factors as bed shortages and failure to meet with commitment criteria. Pogrebin and Poole concluded that due to the changes in the mental health system mentally disordered persons are more commonly arrested by default. This conclusion is congruent with that of Teplin and Pruett (1992). Teplin and Pruett

found in their research investigating police-citizen encounters that 46.7% of the mentally ill suspects were arrested whereas the police only arrested 27.9% of the non-mentally ill suspects observed. The authors concluded from their observations that diversion was often viewed as an unobtainable option due to; stringent commitment criteria, lack of resources, and time restraints, making arrest stand out as a viable option, especially for safety issues. Clearly, the findings obtained from this type of research reinforces the research evidence from investigations on arrest rates and supports the conclusion that mentally disordered persons are at a higher risk of arrest post-deinstitutionalisation.

An Increase of Mentally Disordered in Jails. It is not surprising that with the evidence indicating an increase in police contact and in arrest rates there has been renewed interest in the prevalence of mentally disordered persons in jails. As mentioned in section 1.5., there has been a plethora of research in this area. This has not only been precipitated by the interest in the plight of the mentally disordered but also by overcrowding and the conditions of these penal institutions (Snow & Briar, 1990; Steadman et al, 1989). Hodgins (1995) found in her review of the research in this area that prevalence estimates of mentally disordered persons residing in jails ranged from around 20 to 40 percent. This range is in line with findings of fellow researchers investigating data from the US and other western countries (Prins, 1993; Snow & Briar, 1990; Wardlaw, 1986). There is an absence of research in this area in NZ. However, with the advent of deinstitutionalisation there have been several government inquiries into the plight of mentally disordered persons in penal custody. In the investigation

by the Working Party (1984), for example, it was concluded, based on observational information, that the prevalence of mentally disordered persons in penal custody in NZ is likely to be in line with that found in other western countries (NZ Ministry of Health, 1984). While prevalence estimates are useful, it is somewhat difficult to quantify an exact increase because of the lack of research pre-deinstitutionalisation and the methodological inconsistencies found in this type of research. Nevertheless, there is still sufficient observational information which indicates that there is a significant increase of mentally disordered persons residing in the jail setting. Pogrebin and Poole (1987) reported that in several studies there appeared to be an association between hospital closures and an increase in jail populations in the US. Blair (1973) found, for example, that a county jail population increased by 300 percent with the closure of one California state mental hospital. In conjunction with arrest rate evidence, it is findings such as this that have lead many researchers to conclude that jails or the equivalent have become the repository for the mentally disordered (Bartol, 1991; Belcher, 1988; Durham, 1989; Palermo et al, 1991; Pelissier, 1988; Porporino & Motiuk, 1995; Rice & Harris, 1995).

A Real Increase Post-deinstitutionalisation? The apparent increase of mentally disordered persons coming into contact with the CJS post-deinstitutionalisation is most commonly referred to as the criminalisation of the mentally disordered. As Miller (1992) noted, it is important to mention that the meaning of this term has slightly altered since Abramson (1972) first coined the phrase. An indepth review of the evolution of this theory is not

pertinent to this discussion. The most simplified and commonly used definition of this term, which will suffice for the purposes of this discussion, is the transition of mentally disordered persons from the mental health system to the CJS. Even though it is widely held that the failure of deinstitutionalisation and the relevant legislative changes have brought more mentally disordered persons to the CJS, there is some debate regarding the degree to which these system changes have impacted on such persons' involvement within the CJS and the extent to which mentally disordered persons are "criminalised". It is well established that offenders and mentally disordered persons share similar demographics. In relation to this occurrence it has been put forth that with the progressive increase in crime, the number of mentally disordered persons who meet with the CJS is also likely to increase (Miller, 1992). In other words, what this view holds is that the current increase may simply be a natural increase in relation to the crime rate rather than a direct transition of institutional responsibility due to system and legislative changes. Although this is a legitimate point, the increase would have to be proportionate for this solely to account for such a rise. While it is difficult to accurately quantify the ratio of offenders and MDO, as discussed above, there is sufficient evidence available that indicates that the changes in the mental health system have had an influence on mentally disordered persons meeting with the CJS. McFarland et al (1989), for example, pointed out that demographics alone could not account of the increased proportion of mentally disordered persons found to be arrested in their study. The fact that these two socially deviant groups commonly share similar demographics and yet mentally disordered persons appear to be arrested and detained

in penal custody more frequently and for a longer duration than their non-mentally disordered counterparts, strongly indicates that the contemporary increase in crime can not solely account for the current rise (Porporino & Motiuk, 1995; Pogrebin & Poole, 1987). Methodological problems in the research, most notably the arrest rate investigations, is another issue that has been raised. Issues such as; the samples selected, the definition of a mental disorder, and the time-span involved in assessing arrest rates, have been used to question the validity and reliability of the research in this area. While the methodological inconsistencies in this research area do limit the generalisability of the findings, there is sufficient research evidence which indicates that mentally disordered persons are more vulnerable to arrest post-deinstitutionalisation (Schellenberg et al, 1992). When this is taken into consideration with the research findings from investigations on police contact and the use of diversion options by police, it is apparent that mentally disordered persons' present level of involvement in the CJS is largely related to system and legislative changes rather than current crime rates.

Closing Comment. The methodological inconsistencies in the research in this area unfortunately inhibit the generalisability of the findings to some degree. Nevertheless, the observational information and the divergent research base available provide overwhelming evidence that with more mentally disordered persons residing in the community there is a related increase in police contact and such persons residing in jails. While the current crime rate may account for some of this increase, it is apparent that the changes in mental health policy and legislation

have had a significant influence on this transition of the mentally disordered from the mental health system to the CJS. It is apparent that with more mentally disordered persons meeting with the CJS that this will increase the strain placed on the MHS available to the CJS. The next question is whether there is likely to be a comparable increase in prisons.

1.8.4. INCREASE OF MENTALLY DISORDERED PERSONS IN PRISON.

While it is widely agreed that there is a criminalisation process in operation, it has been held that this process tends to stop at remand. Several authors have suggested that the criminalisation of the mentally disordered only extends to the "revolving door" process (Freeman & Roesch, 1989; Martell, 1991; Miller, 1992; Morrissey & Goldman, 1986). In simple terms, this process is where mentally ill persons who come into contact with the police are arrested, processed through the courts for MHT, only to be released (often prematurely) back into the community where the process begins again. Morrissey and Goldman (1986), for example, found that while other admission options were on the decrease, involuntary commitment by the court was on a slight increase. What this suggests is that, while mentally disordered persons may be more likely to be arrested and remanded into penal custody, such persons may not be at a higher risk of conviction and/or imprisonment, especially for misdemeanours. (Clearly, this process is also argued to inflate arrest rates and such persons' contact with the CJS). However, there is growing evidence that mentally disordered persons are also at a greater risk of conviction and imprisonment in the current social climate.

Increase in Arrest Rate for Violent Offences. While there has been a primary focus on arrest for minor misdemeanours, there is research evidence indicating that mentally disordered persons are at a higher risk of arrest for a violent offence[20]. In the review by Schellenberg et al (1992), one factor that stood out in the research was that there appeared to be a significant proportion of mentally disordered persons arrested for violent offences, especially for assault. Lamb and Grant (1982) found, for example, that in their study of psychiatric jail inmates 52% had felony charges, around half of which were for violent offences (Ashford, 1989). These findings concur with research investigating the impact of homelessness on the mentally disordered, which has largely been attributed to deinstitutionalisation and the associated legislative changes. Belcher (1988) found that 30% (n = 21) of the chronically ill homeless subjects observed were arrested for assault. This finding is consistent with research by Martell (1991), who found that assault was a more common offence for homeless disordered persons than domiciled mentally disordered persons (26.5% vs. 5.8%). Martell also found that a significantly higher proportion of the homeless group were arrested for a violent offence (92.6% vs. 76.7%), however, it is clear that both groups of disordered persons had a high arrest rate for violent crimes. Martell concluded that these findings suggest that mentally disordered persons are more vulnerable to arrest for violence as a result of increased vulnerability within the community due to system changes. Research findings obtained by Steadman (1985) from his US research concur with this conclusion. Steadman found that of the

[20]It is out the scope of this discussion to review the argument that such research findings suggest there is an association between mental illness and violent behaviour.

male patients studied, 60 percent of the 1978 group were arrested for a crime against a person as opposed to 42 percent in the 1968 sample (Schellenberg et al, 1992). Clearly this shows a substantial increase in mentally disordered patients' involvement in violent crimes. What these research findings indicate is that mentally disordered persons appear to be more vulnerable to arrest for violent offences post-deinstitutionalisation.

Not surprisingly, there is some disagreement as to whether this type of increase in arrests is associated with the changes in the mental health system. Again, it has been suggested that these findings are directly related to the increase in crime, especially given the current rate of violent crime. Martell (1991) aptly notes, however, that the varying theories presented to explain these findings are not necessarily mutually exclusive. In other words, the increase rate in violent crime may account, in part, for the increase in arrests of mentally disordered for violent offences. However, Martell also points out the validity of the risk hypothesis theory in this regard and its compatibility with the criminalisation theory. In simple terms, according to this risk theory, mentally disordered persons become more vulnerable to crime with certain situational and environmental factors. In other words, if a mentally disordered person is placed in an environment that requires a level of social functioning beyond their capability, such as unsupported community living, such persons are more vulnerable to exhibiting violent behaviour. Therefore, in line with the criminalisation theory, this view holds that the changes in the mental health system largely account for mentally disordered persons' increased vulnerability within the community, increased

involvement in crime, and in the CJS. Martell concluded that this theory aptly explains why mentally disordered, especially the homeless, appear to be more vulnerable to committing violent offences. This concurs with investigations perusing predictors of violence for mentally disordered persons. Hodgins and Gaston (1989), for example, found that situational factors had some bearing on violent behaviour post-release for inpatients. In other words, it was found that mentally disordered persons with a lack of social stability appear to be vulnerable to violent behaviour. This finding concurs with other research findings on violent recidivism amongst MDO (Klassen & O'Connor, 1988a, 1988b, 1989). What this means is that, while there is some disparity in the research available, there is a reasonable degree of evidence which indicates that more mentally disordered persons are likely to be arrested for a violent offence post-deinstitutionalisation.

Changes in Diversion Options. The changes in the availability and usage of diversion options does not appear to stop with the police. With the demand for better public safety measures and the reduction of mental health resources there appears to be a comparable decrease in diversion availability throughout the CJS. In the US, for example, thirteen states now have the sentencing option of "guilty but mentally ill" (GBMI). While this does not replace the insanity defence per se, the premise behind this option is that it allows the court to acknowledge an offender's mental illness and also find such persons criminally responsible, as opposed to "not guilty by reason of insanity" (NGRI) (Verdun-Jones, 1989). This sentencing option has gained its popularity primarily because it represents the "ideal" scenario whereby MDO can be

both *rightfully* treated and punished, as well as addressing the issue of public safety. There has been significant pressure in NZ and Australia to incorporate the GBMI sentencing option within the respective legal systems (Law Commission of Western Australia, 1991; "The Press", Christchurch, NZ, December 16, 1994). While this option has not been introduction in either country as yet, this pressure highlights the current social dissatisfaction with the availability of diversion away from the penal system. This sentencing option has not received such attention in England simply because there is a comparable option available. The Homicide Act 1957 allows the court reasonable discretionary power at sentencing, which includes the option of sentencing MDO deemed partial responsible to a term of imprisonment with a treatment order. This sentencing option is made possible because MHS are seen to be available for prisoners, with special emphasis placed on Grendon prison's function (Baker, 1993; Prins, 1993). It is also apparent that this option is being utilised by the courts as opposed to diversion. Baker (1993) pointed out that a circular was released by the Home Office to remind criminal justice agencies of diversionary policy. This signifies that a significant proportion of MDO are not being diverted. Clearly, these changes have an impact on the use of diversion options and increase the chance that MDO will reside in penal institutions as opposed to the mental health system.

When perusing the influence of mental health policy and legislative changes, it appears that there is a direct impact on the use of diversion options for mentally disordered persons at this level of the CJP. Dell and Smith (1983) found that in England, there was a

decline in recommendations for hospital orders made to the court and a subsequent reduction in hospital orders to a special hospital for offenders ruled to have diminished responsibility under the Homicide Act. It was concluded by the authors that these changes in recommendations reflected the increase of hospital refusal for such orders due to the changes within the mental health system. Similar findings in England have been reported elsewhere (Baker, 1993; Prins, 1993; Verdun-Jones, 1989). The situation in the US is not that dissimilar. Hochstedler (1986) found, for example, that diversion option usage appeared to be related to the offence type in question, however, the discretionary power of the court was considered an overriding factor in the sanction imposed. It was found that MDO charged with a misdemeanour were less likely to be sentenced than those charged with a felony. However, for those charged with a felony the court was found to impose a custodial disposition either punishment or a hospital order. This finding suggests that public safety issues and mental health system changes bear some influence in this regard. As discussed in section 1.4, Miller (1992) found that the level of community funding available for MHS was the most significant predictor of the court utilising diversion options for MDO. In other words, the more scarce these resources the less likely MDO were found to be diverted away from the penal system. These findings indicate that in the US, the changes in the mental health system have had an influence in the usage of diversion options for MDO, similar to that found in England.

As previously stated, the twin policy of deinstitutionalisation and community care has not been implemented in NZ for as long as in

other countries and there is also a lack of NZ research investigating the plight of MDO. Nevertheless, the changes in the mental health system and associated legislative changes implemented in this country are in line with those found elsewhere, which suggests that the NZ situation is likely to be comparable to other western countries in this regard. As already highlighted, in line with other countries, the definitional criteria depicting what constitutes a mental disorder with regard to inpatient detainment under the NZ Mental Health Act 1992 significantly varies from the definition under the Mental Health Act 1983, to exclude certain clinical disorders. Clearly, this restricts the likelihood of admission and is likely to have a bearing on the use of hospital admissions as a diversion option. More directly, Faed (1992) reviewed the limited research investigating the role of psychiatrist in the court in NZ. She reported that Hill (1980) found that the courts within NZ are more likely to follow psychiatric recommendations the more restrictive these recommendations are. Slightly differing results were obtained by the research conducted by Faed (1992). She found that one third of the assessed remandees ($\underline{n}$ = 344) were given a prison term, in spite of treatment recommendations, however, the majority of those with a recommendation for hospital were sentenced accordingly. It was also found that around one third of the remandees received no treatment recommendation and another third received a recommendation for outpatient treatment. In line with Hochstedler's (1986) research, these findings indicates that in NZ in accord with the US, public safety issues are a prominent concern and that imprisonment may well be imposed for MDO as opposed to treatment. In accord with the research by Dell and

Smith (1983), these findings suggest that the recommendation of inpatient care may reflect bed availability rather than treatment needs. Therefore, in line with other western countries, it is likely that there is a comparable reduction post-deinstitutionalisation in the availability of diversion options at this level in this country.

More Mentally Disordered in Prison. It is important to mention that these changes in the availability and usage of diversion options is likely to have a bearing on the prevalence of mentally disordered persons in jail. While inconsistencies were found, Schellenberg et al (1992) reported that conviction and imprisonment for a misdemeanour was not an uncommon finding in the research perused. Similar findings have been reported elsewhere (Axelson & Wahl, 1992; Porporino & Motiuk, 1995). This indicates that the changes in the mental health system have had an influence on the use and the availability of diversion at court level for less serious offenders. It is also important to note here that due to the forfeiture of rights involved, alleged offenders and lawyers do not peruse the option of involuntary commitment readily, especially regarding trivial offences. Therefore while the police may be motivated to arrest the mentally disordered on humanitarian grounds (i.e. in the aim of ensuring essential MHT), such persons may not opt for this process. What this evidence suggests is that the increase of mentally disordered persons in jails is not solely those remanded to such facilities but also those who are convicted for a misdemeanour.

Understandably, the research indicating that there is an increase of mentally disordered persons arrested for violent offences and a reduction in the availability and use of diversion options at court

level has added to the interest in the prevalence of mentally disordered persons in prison. As the prevalence research has already been reviewed in section 1.5. it is not necessary to peruse the literature in this section. To recap, unlike the literature on mentally disordered persons in jails, there is a lack of research in this area. However, the rate of MDP is thought to be less than that found in jails, depending on the type of disorder in question. While prevalence estimates are essential, in this context with the methodological problems in this research area and the lack of research pre-deinstitutionalisation, it is difficult to quantify if there is a notable increase of mentally disordered persons residing in prison post-deinstitutionalisation. Nevertheless, the later prevalence research in this area has found that there appears to be significantly more MDO residing in prison than early research findings have indicated. Such findings have been attributed to the use of clinically based measures of mental illness. While this is likely to be a significant factor it is possible that an increase of MDP is also being measured. Pogrebin and Poole (1987) reported that there is growing support for the view that the criminalisation process has extended to prison. Greene (1988), for example, reported that there appeared to be a relationship between the declining numbers of inpatients in the New York mental health system and the increase of prisoners in the New York prison. Clearly, this suggests that the deinstitutionalisation process has had an impact on prison numbers. Therefore, while the prevalence research is somewhat equivocal at this point, the research evidence on arrest rates for violent offences and the available evidence regarding changes in diversion indicate that more mentally disordered persons are likely to reside in prison post-

deinstitutionalisation. Several authors have taken the view that, along side jails, prisons are also becoming a repository for the mentally disordered in the current social climate (Bartol, 1991; Durham, 1989; Pelissier, 1988; Porporino & Motiuk, 1995; Rice & Harris, 1995).

Most Vulnerable to Penal Custody. One factor that has come out of the research that is significant in the provision of treatment in prison, is the type of mentally disordered persons most likely to reside in penal custody. The research at police and court level indicate that some MDO are less likely to be diverted for treatment than others. The most vulnerable appear to be those who have a comorbid substance use disorder (Schellenberg et al, 1992; Pogrebin and Poole, 1987). For example, McFarland et al (1989) found that MDO with alcohol or drug problems were more likely to be arrested. In the research by Palermo et al (1991), as previously discussed in section 1.6, it was found that a previous referral for alcohol and/or drug treatment had a negative impact on diversion for MHT. Similar findings have been reported elsewhere (Belcher, 1988; Freeman & Roesch, 1989). Pogrebin and Poole (1987) suggest that this occurs because of specialisation of services. In other words, persons with multiple problems are more likely to be denied access to services because they do not meet the stringent commitment criteria. The nature and severity of a disorder also appears to be an important factor in diversion, mainly pertaining to chronic schizophrenia. There are opposing reports at arrest level. McFarland et al (1989) and Belcher (1988) both found that MDO with chronic schizophrenia were more likely to be arrested. Yet, Teplin and Pruett (1992) and Holly and Arbolea-Florez (1988)

found that the police were more likely to divert severely MDO. However, while Schellenberg et al (1992) found in their review that there were inconsistencies in the research findings regarding the arrest of MDO with schizophrenia, they found that such persons were more likely to be diverted by the courts for treatment. The research by Dell and Smith (1983) concurs with this as they found that offenders who suffered from severe schizophrenia were the most likely to be diverted to hospital. The inconsistency found in the arrest practice for these individuals is likely to relate to the revolving door syndrome. In other words, it would appear that where these individuals are arrested they are more likely to be diverted away from penal custody by the courts. Therefore, this indicates that chronically ill offenders, most notably those with schizophrenia, are still likely to be diverted, however, other MDO, especially those with substance use comorbidity are more vulnerable to incarceration post-deinstitutionalisation.

Closing Comment. As previously mentioned, in most western countries, there has been ongoing controversy regarding the validity of the rehabilitative objective under penal policy. With the growing public discontention with the degree of crime within the community there has been less emphasis placed on the rehabilitation, including the provision of rehabilitative MHS. Cooke (1994), for example, found in his review of the diversion system in Scotland that diversion was not often utilised for humane based and rehabilitative MHT. This suggests that the de-emphasis on rehabilitative MHT may have an impact on the availability of diversion options for this type of treatment. As discussed in section 1.2, the main change in NZ in this regard has been the

introduction of more stringent treatment criteria and a reduction in the availability of such services. This suggests that the changes in rehabilitative diversion options relates more to a change in usage following policy changes rather than legal amendments. Nevertheless, this has produced a subtle reduction in the usage and availability of this type of treatment. This means that more offenders with rehabilitative mental health needs may end up in prison.

1.8.5. SECTION SUMMARY.

While the impetus behind the implementation of the mental health twin policy and the associated legislative changes was the protection of mentally disordered persons' rights, especially that to liberty, it would appear that these changes have served to disadvantage this social group. The literature indicates that due to such factors as; inadequate funding, service specialisation, and the legal emphasis on dangerousness rather than treatment needs, there is a significant reduction in service accessibility in the community, especially inpatient care. The apparent perversity of this situation is that this reduction in resources has coincided with a natural increase in the demand which places further pressure on a diminishing social system. It is clear that with premature hospital closure and more stringent admission criteria there are more mentally disordered persons residing in the community and that ex-patients and would-be new patients are the most vulnerable in the community setting and the most likely group to have limited access to the appropriate form of treatment.

It has historically been acknowledged that mentally disordered persons are vulnerable to contact with the CJS and there have

historically been diversion options available throughout the CJP for the protection of these individuals. However, it is apparent that the availability of these options has historically met with controversy. The primary issue of concern has been offenders' motivation regarding these options, especially with the insanity plea, and additional diversion options for rehabilitative MHT. While certain changes have been introduced over time, most notably in the US, the controversy still remains. It is apparent that there is a demand for further changes in the availability of diversion options due to the low public safety level as a result of the current prevalence of offenders and mentally disordered persons within the community. The research indicates that these factors, in conjunction with the changes in the mental health system, have had a significant impact on the usage of diversion options.

The research findings indicate that there is an increase of mentally disordered persons meeting with the CJS and a decrease in the use and availability of diversion options. There is sufficient evidence available which indicates that the increase in mentally disordered persons in contact with the CJP can not solely be accounted for by the current increase in crime. What the research indicates is that there is a decrease of MDO being diverted away from the penal system due to changes in the CJS and the mental health system. This means that more MDO are residing in penal custody post-deinstitutionalisation, which is likely to place more pressure on an under-developed network of systems placing MDP at a higher risk of human rights infringements.

1.9. GENERAL SUMMARY AND THE CURRENT RESEARCH OBJECTIVES.

1.9.1. A SUMMARY OF THE LITERATURE REVIEW.

It is apparent that convicted offenders' rights are controversial and somewhat unstable given that the socio-political climate and context largely determine the rights afforded. What is clear, however, is that in most common law based societies the moral concept of natural law and the rules of fair play are fundamental to the CJS. It is via these principles that the protection of offenders' basic human rights have historically been argued to be paramount for the provision of justice, equal to the provision of public safety and social retribution. The perusal over penal history in NZ indicates that, in accord with other western countries, several changes have been implemented over time in the endeavour to find a just balance between the protection of offenders' rights and of all citizens' rights. Penal policy implemented prior to the 1970's predominately centred around the issue of improving the rights afforded to offenders. The most significant of these were the establishment of international human rights standards with the incorporation of these into the relevant legislation and the endorsement of the "last resort" policy. These changes signify that the right to liberty is considered a serious right to deny a person and that those persons who are deemed to have forfeited this right, have the right to humane containment. While reform post the 1970's has primarily revolved around the issue of improving public safety levels, the important changes made for the protection of offenders' rights have not readily been revoked. Clearly then, convicted offenders' rights have improved over time mainly via the types of penalties made available to the court.

However, in NZ in line with other western countries, the prison system still functions as the backbone of the penal system and also serves the vital function of incapacitation.

Unfortunately, it is apparent that in most western countries, including NZ, the endeavours to reduce the use of imprisonment have not had a significant impact on the rate of crime. In fact it is clear that in spite of non-custodial and parole initiatives prison numbers have continued to be problematic. With the current social climate of significant rates of violent crime, the social pressure for better public safety measures has brought reform that will ensure prison numbers will not diminish in the near future. Subsequently the problem of overcrowding and the protection of prisoners from human rights infringements is a serious contemporary issue. While there are several important requirements for the humane containment of prisoners, the one essential provision that stands out as a current concern is the provision of MHS given the impact that overcrowding is likely to have on the mental health of prisoners. What is clear is that in NZ, in line with other western countries, MDP have the constitutional right to MHT which is substantiated via section 9 of the NZ Bill of Rights.

As evidenced in section 1.4., it is highly likely that there is a significant gap between MDP' paper right and the practical fulfilment of this right. The legal requirements are inherently vague, constituting minimum standards of care rather than the comprehensive protection of such rights. It is also apparent that the practical fulfilment of entitlements primarily relies on policy which is the weakest form of legal protection. While the objective

in NZ, in accord with other western countries, is to supersede the minimum standards and provide a comprehensive MHS system, it appears that the general policy standards are also quite vague. The evidence suggests that while court action may help to substantiate this important constitutional right, this right appears to lack enforceability due to the nature of the current legal framework. Through the current examination of the ambiguity of the psycho-legal context in question, it is apparent that there are two major problems in this area. The first is that the rationale for the provision of MHS for humane containment requirements and for rehabilitative objectives appear to be blurred. In fact, while the need for humane containment is widely acknowledged in this regard, there appears to be a greater emphasis placed on the provision of rehabilitative MHT under policy. The second problematic issue is what mental health status renders a prisoner eligible for MHT under this constitutional right. It is apparent that not only does the emphasis on rehabilitative objectives intrude here but so does the reliance on minimum standards. Moreover, while the presence of a clinically diagnosable disorder has been affirmed by the courts in the US as the criteria and that this is also the general standard held under policy across western countries, this criteria is still problematic. As discussed, this criteria must be considered within the context at hand. In light of the impact that the prison environment may have on vulnerable prisoners' mental health, especially that of overcrowding, the types of disorders that stand out as those pertinent to this context are psychosis, mood disorders, and anxiety disorders.

What has been evidenced in the review of the prevalence research is that in spite of methodological inconsistencies there appears to be a significant proportion of mentally disordered persons residing in penal custody across western countries which outweighs that found in the general population. While this information affirms the need for MHS in prison, it does not adequately address this issue at the practical level. The main problem with the research in this area is that the investigations have not been conducted within the framework of MDP' right to MHT. The majority of research has not utilised standardised clinically based assessments to establish the presence of a mental disorder and the presence of rehabilitative mental health needs are commonly included. Both of these factors skew research away from the issue of MDP' right to MHT. When the research findings are viewed within the context of humane containment requirements, it would appear that there are around 5 to 10 percent who suffer from some type of psychosis. While the research indicates that there is also likely to be a significant proportion of prisoners who suffer from mood and anxiety problems, the number of those eligible for MHT appears to be an "unknown" quantity. While the issue of co-occurring disorders and substance use comorbidity have not been specifically investigated in this regard, the literature indicates that these factors are a significant problem for mentally disordered persons in penal custody.

The perusal of the detection and referral process in prisons evidences that this vital system has received relatively little attention from legislators, policy-makers and researchers, given its pivotal role in the protection of MDP' rights to MHT. In most

western countries, there is basically no legislative requirement for an identification system. Although court action has been taken in the US, in accord with most western countries the detection and referral process is still primarily a policy matter. It is apparent that this renders MDP vulnerable to human rights infringements given the problems that tend to come with implementing policy standards. The review of this operational procedure indicates that there are several problems commonly found within this system. The areas that stand out are; the type of screening schedules used, the over-reliance on correctional staff, the time of screening, and resource allocation, all of which appear to have some influence on the detection process. The most commonly utilised screening schedule for MDP is a crisis based assessment and the research suggests that even inmates in crisis can be left undetected using this type of evaluation. This indicates that the detection and referral rate of MDP is likely to be relatively low. The research evidence shows that MDP who; have current positive or overt symptomatology, are severely disordered, are disruptive, have mental health history on file, and have atypical "criminal" personality characteristics, appear to be the most likely to be detected. Even though the provision of rehabilitative MHT is a policy objective rather than a legislative requirement, it is apparent that these policy standards are more articulated than humane containment requirements. This is evidenced in the identification process as criminogenic needs assessments appear to be the most comprehensive part of the identification system found across countries. This indicates that prisoners in need of rehabilitative MHT may be more likely to be detected than MDP.

The investigation into the delivery of MHT within prisons has shown that this independent system has problems comparable to the detection and referral process. In NZ, in accord with other western countries, unlike the identification system there are more definitive legislative requirements for the provision of MHS. However, even though these requirements are in line with international human rights standards, these requirements function as minimum standards and the practical provision of MHS is still primarily subject to policy standards. Across countries, while there is some variation in the services provided, there appears to be a reasonable number of services available for prisoners, complying with the policy objective of providing a comprehensive MHS system. However, it is apparent that when accessibility is perused as opposed to availability, the provision of treatment for this category of offenders appears to be extremely limited. The main problems that appear to inhibit the delivery of MHT are; resource limitation, system and service co-ordination, and the narrow refocus on chronicity under policy guidelines and in the prioritisation process. While there is a lack of empirical research in this area the available literature indicates that crisis intervention is the most likely form of MHT available for MDP in real-terms. Clearly, what this means is that the delivery rate of MHT is likely to be reasonably low. While the delivery of rehabilitative MHT also appears to have been effected by these aforementioned factors, most notably resource limitation, it is likely that the delivery of rehabilitative MHT will surpass the provision of MHT for MDP given that this criminogenic need is more defined under policy. The limited research in this area indicates that MDP who: are severely disordered, have positive or overt

symptomatology, have mental health history on file, and have atypical "criminal" personality characteristics, appear to be the most likely to be offered MHT.

The review of the changes in the mental health system indicates that the twin policy of deinstitutionalisation and community care with the associated legislative changes has had a significant impact on the plight of mentally disordered persons, especially those that meet with the CJS. The implementation of this twin policy has increased the number of mentally disordered persons within the community and has reduced the availability of mental health facilities. It is apparent that the current social climate of low public safety levels and limited resources have reduced the availability and the usage of diversion options throughout the CJP. The research indicates that as a result of these changes there are more mentally disordered persons residing in penal custody post-deinstitutionalisation. There has been some debate as to whether this is simply a natural increase given the general increasing crime rate. However, there is sufficient evidence indicating that this twin policy is directly related to an increase of MDO in penal custody. This finding clearly adds urgency to the issue of the protection of MDP rights to MHT given the nature of the legal framework and that the network of systems in operation to fulfil this right appear to be under-developed.

1.9.2. THE CURRENT RESEARCH OBJECTIVES, AIMS AND HYPOTHESES.

It is apparent that there is a lack of comprehensive empirically based research in this area and that there is simply an absence of research in NZ. The present multifaceted research was designed to investigate this important human rights issue

within the framework of prisoners' rights to ascertain if there is a gap between MDP paper and practical right to MHT and to add some empirically based information which is essential for the implementation of practical solutions in this area.
There are two considerations in this research. The primary consideration is the humane containment of MDP. The focus here is on the protection of MDP' right to MHT under humane containment requirements. The secondary consideration is prisoners' access to rehabilitative MHT. This was included because the provision of MHT for rehabilitative objectives appears to detract attention from humane containment objectives. The main purpose of including this consideration was for comparative analysis. There are three research objectives with corresponding aims and hypothesis.

The first objective was to establish an estimated base rate of MDP in NZ. The aim was to ascertain the prevalence of MDP who are entitled to MHT within the framework of prisoners' right to MHT under humane containment requirements. Given the research findings in this area it is clear that a standardised clinically based schedule is essential for the screening of prisoners as this provides a comprehensive operational definition of a mental disorder and lessens the chance of mentally disordered persons being missed in the assessment process. In line with the available evidence the first research hypothesis was that the prevalence rate established in the current research would be higher than survey estimates.

The second objective was to quantify the detection and referral process in operation for MDP. The first aim of this objective

was to verify the efficiency of this identification system by quantifying the accuracy rate of the detection and referral of MDP. In line with the available literature the second research hypothesis was that the detection/referral accuracy rate would be reasonably low. The second aim of this objective was to ascertain what variables influence detection and referral. Multivariate analysis was used to verify the predictive power of selected variables in the likelihood of detection and referral. This form of analysis should provide a comprehensive profile of persons who are more likely to be detected and should also provide some essential insight into the nature of the detection process in operation. In line with the evidence available the third hypothesis was that; current mental disorder factors, mental health history, personality traits, and substance use status would have an impact on detection and referral. The final aim of the second objective was to ascertain whether the detection and referral of rehabilitative mental health needs would be more efficient than the detection and referral of MDP. This comparative assessment involved the analysis of the accuracy rate of referrals for prisoners in need of three primary rehabilitative mental health needs. Given the emphasis placed on the rehabilitative objective the fourth research hypothesis was that the detection and referral of prisoners for rehabilitative MHT would be more efficient than the detection and referral of MDP.

The third objective of this research was to quantify the efficiency of the treatment delivery system for MDP. In line with the identification system, the first aim was to ascertain

the accuracy rate of treatment delivery. In light of the research evidence the fifth research hypothesis was that the delivery rate would be relatively low. The second aim of this objective was to ascertain what variables had an impact on the provision of MHT. The sixth research hypothesis was that; current mental disorder factors, mental health history, and personality traits would influence treatment delivery. Given the concern that crisis intervention appears to be the most prevalent form of treatment provided it was of interest to peruse the types of MHT offered. This constituted the third aim of this objective, and the seventh research hypothesis was that the primary form of MHT provided would be crisis oriented. The fourth and final aim of the third objective was to ascertain whether the provision of rehabilitative MHT was more efficient than the provision of humane containment based MHT. Again this was limited to the assessment of the provision of MHT for the three primary rehabilitative mental health needs. In line with the literature the eighth and final research hypothesis was that the delivery of rehabilitative MHT would be more efficient than the provision of MHT for MDP.

Chapter Two

METHOD

2.1. PARTICIPANTS.

The issue of protecting MDP' right to MHT under humane containment is important for all inmates. The present aim is to ascertain the degree of protection available for inmates in general. This means that it is necessary to quantify the protection of these rights for "mainstream" inmates, or in other words, male inmates residing in medium security facilities. Christchurch Men's Paparua Prison, a local medium security prison, has a maximum capacity of 536 prisoners. The East and West wings of the central prison building collectively have the maximum capacity of 184 prisoners and are the major medium security units at Paparua Prison. It was from these two wings that the randomised research sample was drawn, which comprised of 100 participants.

2.2. MATERIALS.

2.2.1. THE STRUCTURED CLINICAL INTERVIEW FOR THE DSM-III-R (SCID).

As discussed in the literature review, methodological inconsistencies found in the research investigating prevalence rates of MDO in penal custody have seriously impeded the generalisability of the findings. Therefore in establishing a base rate of MDP in the current study, the most important consideration was the validity of the screening schedule. On these grounds the SCID was selected for this study because it is the only structured schedule thus far that precisely mirrors the clinical diagnostic criteria of a widely recognised standardised assessment of mental

disorders, namely the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) (Spitzer, Williams, Gibbon, & First, 1992). The SCID has proven validity, interrater and test-retest reliability, and research has shown that this instrument has internal validity in line with other well established structured interview schedules (Riskind, Beck, Berenick, Brown, & Steer, 1987; Spitzer, et al, 1992; Williams, et al, 1992).

The SCID is designed in modular form which allows the researcher to easily modify the interview schedule in accordance with the research question, without affecting the overall validity or reliability of the instrument (Spitzer, et al, 1992). The version of the SCID selected for this study was the patient edition with psychotic screening (SCID-P W/PSY SCREEN), which was chosen because an overview of basic demographic data and a brief inquiry into the general physical and mental health of the participant is included. This allows the interviewer to develop an initial rapport with the participant and provides a point of reference for potential 'hot-spot' areas which can serve as a guideline for the interview. The disorder modules selected were those that clearly fell within the psycho-legal context in question. The psychoactive substance use disorder module was included for comparative analysis.

The SCID modules included for this research are as follows (see appendix b for a copy of the SCID);

(a) Mood Disorders:
- •Current and Past Major Depressive Syndrome
- •Current and Past Manic Syndrome
- •Current Dysthymia

(b) Psychotic Screening

(c) Psychoactive Substance Use Disorder
- •Alcohol
- •Non Alcohol

(d) Anxiety Disorders
- •Panic Disorder with and without Agoraphobia
- •Agoraphobia without a history of Panic Disorder (AWOPD)
- •Social Phobia
- •Simple Phobia
- •Obsessive Compulsive Disorder
- •Generalised Anxiety Disorder (GAD)

2.2.2. THE TEMPERAMENT AND CHARACTER INVENTORY (TCI)

The TCI was the instrument selected to measure inmates' personality traits to ascertain if this factor has an influence in the referral process (see appendix c). This personality schedule is a 238 self-report questionnaire and is based on Cloninger's Biosocial Learning Model (Cloninger, 1987). In basic terms, the underlying theory of this model is that the personality traits of an individual are a result of the interaction between genetic and fundamental biology (the temperament) and environmental and situational conditions (the character) (Cloninger, 1987; Cloninger, Svrakic, Przybeck, & Cloninger, 1993). The TCI is a modification of Cloninger's original three factor scale, the Tridimensional Personality Questionnaire (TPQ). Research based on the TPQ has shown that this inventory has internal and external validity, in line with other personality schedules (Cloninger, 1987; Waller, Lillenfeld, Tellegen, & Lykken, 1991).

The temperament scales of the TPQ (novelty seeking, harm avoidance and reward dependence) have been shown to differentiate between types of alcohol and drug disorders and

types of eating disorders (Bulik, Sullivan, Weltzin, & Kaye, 1995; Earleywine, Finn, Peterson, & Pihl, 1992). Moreover, with the inclusion of the self-concept characters, the TCI has been found to have greater precision then the TPQ at delineating between personality trait clusters and has been found to be a valid predictor of mental disorder types (Bulik, Sullivan, Joyce, & Carter, 1994; Cloninger, et al., 1993; Svrakic, Whitehead, Przybeck, & Cloninger, 1993). These findings support Cloninger's biosocial model of personality constructs and show that the TCI is a useful clinical tool in discerning personality traits and types of clinical disorders. As shown in Table 1[21]., the TCI is a seven-factor inventory where temperament is measured along four dimensions and the remaining three dimensions assess the self-concept characters. Average scores on the temperament scales and upper range scores on the character scales are indicative of normal social functioning and thus adaptive personality traits.

[21]This table was adapted from Cloninger et al., (1993).

Table 1. TEMPERAMENT AND CHARACTER SCALES OF THE TCI.

TEMPERAMENT	Sub-scales	No. of Items	High Score	Low Score
Novelty Seeking (NS)	4	40	Impulsive, prodigal, excitable and non-compliant	Regimented, rigid, reserved and reflective
Harm Avoidance (HA)	4	35	Fearful, worrisome, shy and fatigued	Optimistic, confident, sociable and energetic
Reward Dependence (RD)	3	24	Dependent, sentimental and attachment	Insensitive, detached and independent
Persistence (P)	1	8	Determination	Indecisiveness
CHARACTER	**Sub-scales**	**No. of Items**	**High Score**	**Low Score**
Self Directedness (SD)	5	44	Resourcefulness, prompt automation of tasks, responsibility, goal-directedness and self acceptance	Blaming, apathy, lack of goal direction and general self-doubt
Co-operativeness (C)	5	42	Empathy, helpfulness, compassionate, selflessness and acceptance	Intolerance, disinterested, revengeful, unhelpful and self-serving
Self-Transcendence (ST)	3	33	Self-forgetfulness, high spiritual acceptance and low individualisation	High materialism, self-consciousness and low awareness of nature

2.3. OPERATIONAL DEFINITIONS

2.3.1. MENTAL DISORDER.

As previously highlighted, the DSM-III-R is an internationally accepted system for the classification of clinical mental disorders. Therefore the SCID diagnostic criteria functioned as the operational definition for a mental disorder in the current study, which provides methodological consistency and allows for generalisability regarding research immediately pertaining to MDO and to the broader study of psychopathology.

The SCID current threshold criteria for the presence of a clinical disorder was taken as the defining criteria for a current mental disorder. The severity of a current mental disorder was excluded from the operational criteria and coded as an independent variable. For simplicity with respect to data analysis, severity ratings were coded as; (a) Severe, (b) Moderate, and (c) Mild. In accordance with the SCID criteria all participants coded as having a current mental disorder must have had the corresponding symptoms for a minimum period of one month prior to the interview. In line with the research rationale only participants who meet the current threshold criteria for psychosis[22], a mood disorder and/or an anxiety disorder were deemed eligible for MHT under humane containment and therefore coded as mentally disordered. The presence of co-occurring disorders was pertinent to this research. In accordance with the research framework and for clarify in the analysis, the disorder with the most positive or overt symptoms was coded as the primary disorder for each disordered participant.

Alcohol and drug dependence are defined as a mental disorder in accordance with the SCID criteria. However, alcohol and drug problems have been associated with offending behaviour and subsequently the provision of treatment primarily falls under the government's responsibility to provide rehabilitative MHS in accordance with current penal policy. Consequently, for the purpose of this study, substance use disorder was excluded from the operational definition of a mental disorder.

[22] For simplicity mood disorders with psychotic symptoms were coded under psychosis.

2.3.2. SUBSTANCE USE DISORDER.

The SCID criteria for substance abuse and dependence was taken as the defining criteria for the presence of a substance use disorder. The SCID lifetime module was utilised to quantify alcohol and non-alcohol substance use, as this provides a comprehensive assessment of psycho-substance dependence and/or abuse. However, only those participants who meet the SCID criteria for substance abuse and/or dependence, for the time span immediately prior to incarceration for the current conviction to the time of the interview, were viewed as eligible for rehabilitative MHT under reintegration policy for alcohol and drug related issues.

2.3.3. TYPE OF CRIME.

The primary offence for which each participant received the current prison term was recorded as the current type of crime. The offence categories were sub-divided according to the NZ Police offence coding format. This coding system is based on a four digit code which is designed to supply specific information as to the nature and severity of the offence. The research categories match the police codes only according to the first digit, which relates to the type of offence[23].

Each type of crime category was coded as follows:

- (1) Violent Non Sexual (1000)
- (2) Violent Sexual (victim) equal to and over 16 years of age (2000)
- (3) Violent Sexual (victim) under 16 years of age (2000)

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[23]The "most common previous offence" and "most serious previous offence" categories were also coded using this criteria.

- (4) Drugs (and antisocial behaviour) (3000)
- (5) Dishonesty (4000)
- (6) Traffic (9000)

2.3.4. SEXUAL OFFENCE.

Only the participants who were serving a **CURRENT** prison term for a sexual offence (violent sexual ≤ 16 years and violent sexual > 16 years) were viewed as eligible for MHT under reintegration policy for sexual offence related issues.

2.3.5. VIOLENT OFFENCE.

Only the participants who were serving a **CURRENT** prison term for a violent offence (including sexual offences) were viewed as eligible for MHT under reintegration policy for violent offence and anger related issues.

2.3.6. DETECTION (REFERRAL) AND TREATMENT CRITERIA.

The operational definition for detection was a referral for the type of MHT required to the appropriate MHS. It should be noted that MHT is provided by multiple services from correctional based agencies such as the Department of Justice Psychological Services (DJPS) and the prison medical unit and from community based agencies such as Regional Forensic Services and Queen Mary Hospital. A referral to and treatment offered by the above agencies constituted the major data base.

MHT was used as the generic term for the requirement and delivery of psychiatric and/or psychological treatment for a clinical disorder and for rehabilitative needs and it also included a range of treatment responses such as a transferral to a psychiatric hospital, medication, individual counselling, and group therapy.

The definition of treatment included cases of assessment only. If a participant had declined offered referral(s) and/or treatment this was viewed as a match regarding detection and/or treatment. Temporal correspondence was required for all referrals and treatment sessions to be recorded as a double match with respect to detection and follow-up treatment offered.

Mental Disorder. To be recorded as detected a participant with a current mental disorder had to have an applicable referral present on file (criminal justice file (CJF) and/or Medical File). A participant without a mental disorder needed to be seen accordingly, that is no referral. To be coded as treated, a mentally disordered participant had to have a record on file of a referral for the disorder and a record of treatment offered (in progress or just completed), in relation to the time the screening interview took place. Only referrals and treatment offered that specifically related to the operational definition of a mental disorder were included.

Substance Use Disorder. Any referral and follow-up treatment offered, at any time during the current sentence was seen as detection and treatment respectively. Only referrals and treatment offered that specifically related to substance abuse issues were deemed applicable to this category and coded accordingly.

Sexual Offence. A referral and corresponding treatment offered, at any time during the current sentence was seen as detection and treatment respectively. Only referrals and treatment offered that

specifically related to sex offence related issues were deemed applicable to this category and coded accordingly.

Violent Offence. A referral and follow-up treatment offered, at any time during the current sentence was seen as detection and treatment respectively. Only referrals and treatment offered that specifically related to violence offence and anger issues were deemed applicable to this category and coded accordingly.

2.4. PROCEDURE.

2.4.1. SELECTION OF PARTICIPANTS.

The researcher randomly selected 100 inmate names, 50 from each of the respective wing muster lists provided. In total, eight men (seven from the East wing) chose not to participate. These men were replaced by subsequent voluntary participants, randomly selected from the respective wings. Out of the 100 participants finally selected, six were omitted (four from the East wing) due to incomplete data. Two men did not return their personality questionnaires (TCI), one participant's criminal justice file was unavailable and the remaining three participants were transferred to another prison, which limited access to their respective medical files. Four (two from each wing) out of the six omitted participants suffered from a mental disorder; one had psychosis, two suffered from a mood disorder and the remaining inmates had an anxiety disorder. The final study sample was therefore reduced to a total of 94 participants.

2.4.2. THE INTERVIEW.

The unit managers of the East and West wings of Paparua Prison officially informed the residing inmates (by means of a written

notice) that there was a researcher conducting a study who may invite them to participate. The selected participants were individually requested by prison staff to accompany the interviewer to private office space. The inmates were advised that participation was voluntary and that they could decline or withdraw consent at any time. Participants were guaranteed confidentiality, especially with regard to the prison authorities. Participants were also made aware that participation would only count towards the study and not reward them in any way, with respect to their custodial circumstances. The interviews did not commence until the procedural information had been discussed and the participants' informed consent had been given (See appendix (a) for a copy of the consent form).

The author was the sole interviewer for the present study. Ongoing professional support was made available for feedback and debriefing throughout the data collection process. All interviews were conducted in private office space provided in each respective wing. The interviews required the completion of the SCID, which averaged three hours in length. In acknowledgement of the high estimated rate of illiteracy within the prison population, the interviewer gave all the participants the option to either complete the TCI questionnaire in their own time or to proceed with it in the interview. Consequently thirty-two participants choose to have the TCI administered by the interviewer, not all of whom were illiterate. After completion of the SCID, due to the nature of the information often disclosed, the participants were given the opportunity to reach a sense of closure before the interview was officially ended. Participants who requested further contact with

a psychologist were personally referred by the author to the Department of Justice Psychological Services.

2.4.3. DATA COLLECTION.

The participants' criminal justice and medical files were the primary data source for; demographic characteristics, offence variables, mental health history, referral and treatment information. Each participant's criminal justice file (CJF) was not reviewed until after he had been interviewed. This procedure was chosen to decrease the chance of interviewer bias with respect to the nature of the inmate's criminal activities recorded on file. A time-delay between assessment and data collection was provided to allow for appropriate detection and treatment provision to be actioned and recorded. The CJF were reviewed within a minimum period of three weeks after the interview took place, whereas the medical files were reviewed within a minimum period of six months after the interviews.

Information regarding whether a participant had been referred to and/or treated by a departmental psychologist was obtained directly from the DJPS. Only such information that related to the participants' current sentence was required. The format of the information provided was (a) the date, the referral agency and reason for referral and (b) the date, number of session(s) and the reason for treatment. In supplying the information in this manner the confidentiality of the participants was maintained. This information was used as a cross reference for current inmates' referral and treatment information collected from the criminal justice and medical files.

2.4.4. CODING PROCEDURE.

The four possible outcomes of detection are illustrated in Figure 1. The ideal situation is a 100% hit rate (i.e. true positives and true negatives) which signifies that the system is functioning at the optimal level of efficiency. The advent of a *false positive* for detection means that a prisoner who does not require MHT is referred for this service and in real terms this equates to inappropriate utilisation of resources. A prisoner who is inappropriately **not** referred for MHT constitutes a *false negative* which equates to a degree of human cost within the system. While these four possible outcomes are also applicable to treatment delivery, given the nature of the current study only a True Positive and False Negative are relevant for this part of the analysis. As shown in Figure 1., The non-detection of a prisoner in need of MHT becomes a more immediate social issue upon the inmate's release because without such treatment (which he is entitled to under humane containment principles) a MDP is likely to be in a more vulnerable condition than when he entered the penal system. Moreover, prisoners who are in need of rehabilitative MHT but are not offered such treatment while being punished for their crime, have been denied the opportunity actively to understand and change their offending behaviour through treatment. Although it is difficult to measure in real terms, the cost to society through recidivism and use of community based services is likely to exceed the expense of providing the appropriate services within corrections.

Figure 1. **THE FOUR POSSIBLE OUTCOMES OF DETECTION.**

True Positive HIT e.g. mentally disordered prisoners appropriately referred.	**False Positive** MISS e.g. non mentally disordered prisoners inappropriately referred.
False Negative MISS e.g. mentally disordered prisoners inappropriately not referred.	**True Negative** HIT e.g. non mentally disordered prisoners appropriately not referred.

All referral and treatment information was recorded along a time line for each participant with respect to their current sentence. The relevant referral and treatment information was coded under the applicable category heading (mental disorder; substance use disorder; sexual offence and violent offence). Following the time line and according to the time when the participant was assessed by the author, detection and treatment hits and misses were coded. Fifty percent of the participant sample were then independently coded by the author's supervisor of studies to test for inter-rater reliability. Agreement was found in 94% of the cases and in the few cases where hit and miss disagreement was found, these were re-coded based on joint agreement.

Chapter Three

RESULTS

3.1. DEMOGRAPHIC CHARACTERISTICS OF THE PARTICIPANT SAMPLE.

The demographic characteristics of the participants are provided in Tables 2(a) through to Table 2(g). The age of the participants ranged from 17.6 to 63.8 years. As shown in Table 2(a), over half the sample (n=63) fell within the 20 to 34 age groups. The mean age was 30 years 3 months with a standard deviation of 9 years 1 month.

Table 2(a). **AGE CHARACTERISTIC OF THE PARTICIPANTS.**

Characteristic	*Sample*	
Age	N	Percent
14-19	08	8.5
20-24	23	24.5
25-29	23	24.5
30-34	17	18.0
35-39	09	9.6
40-49	11	11.7
50+	03	3.2
Total	**94**	**100.0**

The ethnicity of the participants is presented in Table 2(b). Just under two thirds of the sample were New Zealand European whereas twenty seven participants were of Maori descent.

Table 2(b). **ETHNICITY CHARACTERISTIC OF THE PARTICIPANTS.**

Characteristic	*Sample*	
Ethnic Origin	N	Percent
N Z European	61	65.1
N Z Maori	27	28.7
Pacific Islander	03	3.2
Other	03	3.2
Total	**94**	**100.0**

The majority of the participants (72.3%) were receiving the unemployment benefit before arrest (Table 2(c)). Only 18 participants had some form of employment before the current arrest.

Table 2(c). **OCCUPATION CHARACTERISTIC OF THE PARTICIPANTS.**

Characteristic	*Sample*	
Occupation	N	Percent
Unemployment	68	72.3
Domestic Purpose	03	3.2
Invalid Benefit	05	5.3
Labour/Driving	10	10.7
Trade	05	5.3
Other	03	3.2
Total	**94**	**100.0**

As shown in Table 2(d), when the participants' occupations were categorised with respect to socio-economic status (SES)[24], the data revealed that 80.9% of the participants were from the under class whereas there were no participants from the upper class bracket.

[24] Hughes' and Lauder's (1990) modification of the Elley-Irving Socio-Economic Index (1981 edition) was utilised to code participants' SES.

Table 2(d). **SES CHARACTERISTIC OF THE PARTICIPANTS.**

Characteristic	*Sample*	
SES	N	Percent
Upper Class	00	0.0
Middle Class	03	3.2
Working Class	15	15.8
Under Class	76	81.0
Total	**94**	**100.0**

The scholastic attainment of the participants is presented in Table 2(e). Education level was condensed into three categories and the data showed that the majority (66%) of the participants had a maximum achievement of fourth form level.

Table 2(e). **EDUCATION CHARACTERISTIC OF THE PARTICIPANTS.**

Characteristic	*Sample*	
Education Level	N	Percent
Under Form 5	62	66.0
Form 5	27	28.7
Over Form 5	05	5.3
Total	**94**	**100.0**

The majority of the sample (70.2%) were single at the time of arrest for the current conviction. As shown in Table 2(f) the remaining participants were either in a relationship prior to the current arrest or separated (including divorced and widowed).

Table 2(f). **MARITAL STATUS CHARACTERISTIC OF THE PARTICIPANTS.**

Characteristic	*Sample*	
Marital Status	N	Percent
Single	66	70.2
Married (de facto)	20	21.3
Separated	08	8.5
Total	**94**	**100.0**

The data on gang affiliation, as shown in Table 2(g), revealed that 86.2% of the participants professed to be neutral in this regard. Only 13 participants claimed to have a current gang affiliation.

Table 2(g). **GANG AFFILIATION CHARACTERISTIC OF THE PARTICIPANTS.**

Characteristic	*Sample*	
Gang Affiliation	N	Percent
None	81	86.2
White Power	07	7.5
Black Power	06	6.3
Total	**94**	**100.0**

3.2. COMPARISON BETWEEN THE PARTICIPANT SAMPLE AND THE N.Z. MALE NATIONAL POPULATION.

A comparison of demographic characteristics and sentence length between the research sample and the New Zealand national (male) prison population is presented in Table 3 (NZ Department of Justice, 1993). The sample age distribution is a good representation of the national prison population. The comparison showed a slight over-representation in the 25 to 29, 30 to 34 and 40 to 49 age groups, with a slight under-representation in the 14 to 19, 20 to 24, 35 to 39 and the 50-plus age groups. When ethnicity was compared the data showed that the research sample had a notable over-representation of New Zealand European participants (20.1%) and an under-representation of New Zealand Maori participants (15.9%). Pacific Islanders and the "Other" category were only marginally under-represented by 6.0% and 0.2% respectively. In comparing current sentence length, the participant sample was found to be a good representation of the national prison population as it was found to follow a similar trend in the frequency distribution within and between groups. As

expected, there was an under-representation of the lower sentence groups and an over-representation of the higher sentence groups, as this sample was exclusively medium security.

Table 3. **COMPARISON BETWEEN THE PARTICIPANT SAMPLE AND THE NEW ZEALAND (MALE) PRISON POPULATION.**

Characteristic	*Sample*		*Population*		*Difference*
Age	N	Percent	N	Percent	Percent
14-19	08	8.5	410	11.2	-2.7
20-24	23	24.5	1064	29.0	-4.5
25-29	23	24.5	808	22.0	2.5
30-34	17	18.0	554	15.1	2.9
35-39	09	9.6	325	8.9	0.7
40-49	11	11.7	338	9.2	2.5
50+	03	3.2	164	4.5	-1.3
Ethnic Origin	N	Percent	N	Percent	Percent
N Z European	61	64.9	1497	43.6	20.1
N Z Maori	27	28.7	1490	43.6	-15.9
Pacific Islander	03	3.2	313	9.2	-6.0
Other	03	3.2	116	3.4	-0.2
Sentence Length	N	Percent	N	Percent	Percent
Under 3 mths	0	0.0	43	1.2	-1.2
3 mths to 6 mths	0	0.0	272	7.4	-7.4
6 mths to > 1 yr.	5	5.3	629	17.2	-11.9
1 yr. to > 2 yrs	13	13.8	739	20.2	-6.4
2 yrs to > 3 yrs	17	18.1	447	12.2	5.9
3 yrs to > 5 yrs	17	18.1	644	17.6	0.5
5 yrs to > 7 yrs	15	16.0	379	10.3	5.7
7 yrs to > 10 yrs	13	13.8	211	5.8	8.0
10 yrs and over	02	2.1	76	2.1	0.0
Life	09	9.6	183	5.0	4.6
P. D.	03	3.2	40	1.1	2.1

3.3. THE PREVALENCE OF MDP IN THE CURRENT STUDY.

To reiterate, the operational definition for a mental disorder was the DSM III R diagnostic criteria for a current mental disorder. The three generic types of mental disorders screened for were psychosis, mood and anxiety. The results of the SCID interviews showed that 62.8% (n=59) of the 94 participants had at least one mental disorder. The prevalence of disorder type, comorbidity and

disorder severity are presented in the following sub-sections. All three variables are presented showing single and multiple disorders.

3.3.1. THE PREVALENCE RATE OF DISORDER TYPE AMONG PRISONERS.

The prevalence rate of anxiety disorders, mood disorders and psychosis among the 59 MDP is presented in Table 4(a). through to Table 4(d)., and is illustrated in Figure 2. The most prevalent type of disorder was anxiety. Forty three (72.8%) men suffered from at least one anxiety disorder. As shown in Table 4(a)., twenty of these participants suffered from one or more forms of anxiety exclusively. The other twenty three inmates suffering from at least one anxiety disorder also had co-occurring psychosis or a mood disorder.

Table 4(a). **PREVALENCE OF PARTICIPANTS WITH AN ANXIETY DISORDER.**

Type of Disorder	Prevalence of Anxiety Disorders	
Anxiety Disorder	N	Percent
Single Anxiety Disorder Only	14	23.7
Multiple Anxiety Disorders Only	6	10.2
Total	**20**	**33.9**
Anxiety Disorder Only (at least one)	20	33.9
Anxiety disorder (at least one) with/out Psychosis with/out Mood Disorder	23	38.9
Total	**43**	**72.8**

Table 4(b) shows the rate of individual anxiety disorders among the forty three prisoners with an anxiety disorder. Social phobia was the most prevalent type of anxiety disorder (n=23) whereas no participants suffered from GAD. Out of the twenty prisoners who suffered from at least one anxiety disorder exclusively, 70% had a single anxiety disorder.

Figure 2. PREVALENCE OF EACH TYPE OF MENTAL DISORDER AMONG THE PARTICIPANTS.

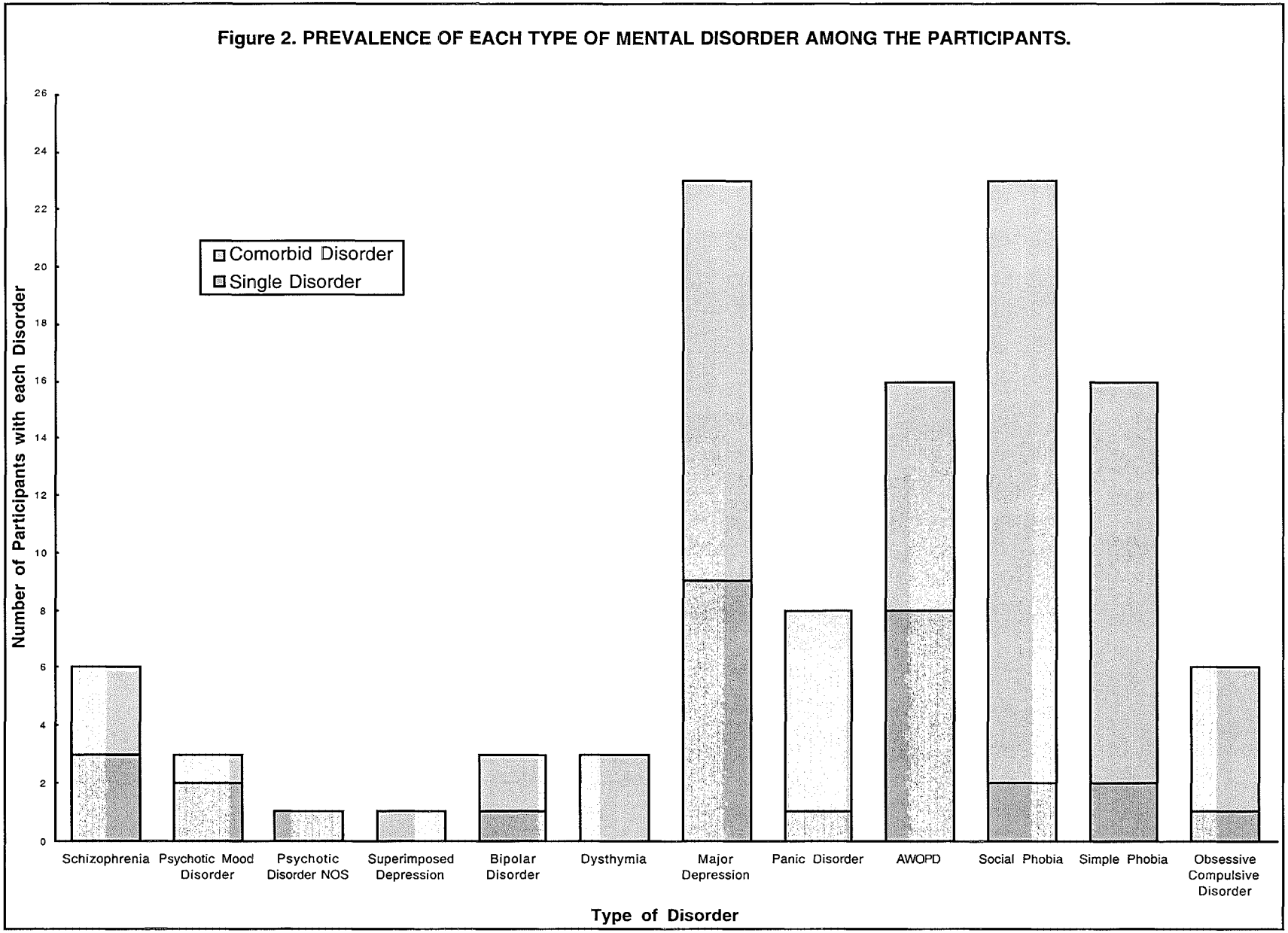


Table 4(b). **SUB-CLASSIFICATION OF THE PREVALENCE OF PARTICIPANTS WITH ANXIETY DISORDER/S.**

Type of Disorder	*Prevalence of Individual Anxiety Disorders*			
	Single Disorder	Comorbid Disorder	**Total**	
Anxiety Disorder	N	N	N	Percent
Panic Disorder	1	7	**8**	**13.5**
AWOPD	8	8	**16**	**27.1**
Social Phobia	2	21	**23**	**39.0**
Simple Phobia	2	14	**14**	**23.7**
Obsessive Compulsive	1	5	**6**	**10.2**
GAD	0	0	**0**	**00.0**

Just over half (50.8%) of the MDP had a mood disorder. As shown in Table 4(c), ten of the thirty participants with a mood disorder had a single diagnosis, while the remaining twenty participants had at least one additional disorder (psychosis and/or anxiety). The majority of the prisoners with a mood disorder suffered from major depression.

Table 4(c). **PREVALENCE OF PARTICIPANTS WITH A MOOD DISORDER.**

Type of Disorder	*Prevalence of Mood Disorders*			
	Single Disorder	Comorbid Disorder	Total	
Mood Disorders	N	N	N	Percent
Superimposed Depression	0	1	1	1.6
Bipolar Disorder	1	2	3	5.1
Dysthymia	0	3	3	5.1
Major Depression	9	14	23	39.0
Total	**10**	**20**	**30**	**50.8**

Psychosis was the least prevalent type of disorder. Only ten (16.9%) of the MDP suffered from psychosis (Table 4(d)). Six of these participants had a single disorder of psychosis only, while the remaining four had at least one other disorder (mood and/or

anxiety). The most common type of psychosis was schizophrenia (60%).

Table 4(d). **PREVALENCE OF PARTICIPANTS WITH PSYCHOSIS.**

Type of Disorder	*Prevalence of Psychosis*			
	Single Disorder	Comorbid Disorder	Total	
Psychosis	N	N	N	Percent
Schizophrenia	3	3	6	10.2
Psychotic Mood Disorder	2	1	3	5.1
Psychotic Disorder NOS	1	0	1	1.6
Total	**6**	**4**	**10**	**16.9**

3.3.2. PREVALENCE RATE OF PRISONERS WITH DISORDER COMORBIDITY.

In total thirty participants had a single disorder (psychosis or a mood disorder or an anxiety disorder). Just under half of the MDP (n=29) had a co-occurring disorder. As shown in Table 5(a) and Figure 3, the majority of the prisoners with comorbidity had three co-occurring disorders.

Table 5(a). **DISORDER COMORBIDITY AMONG THE PARTICIPANTS.**

Number	*Comorbidity*				
	One Disorder	Two Disorders	Three Disorders	Four Disorders	Total
Total	30	10	16	3	59

Comorbidity and disorder type are presented in Table 5(b) and illustrated in Figure 4. The majority of the participants who suffered from co-occurring disorders had a mood disorder and at least one anxiety disorder (n=19). Only one participant had psychosis, a mood disorder and at least one anxiety disorder.

Figure 3. DISORDER COMORBIDITY AMONG PARTICIPANTS.

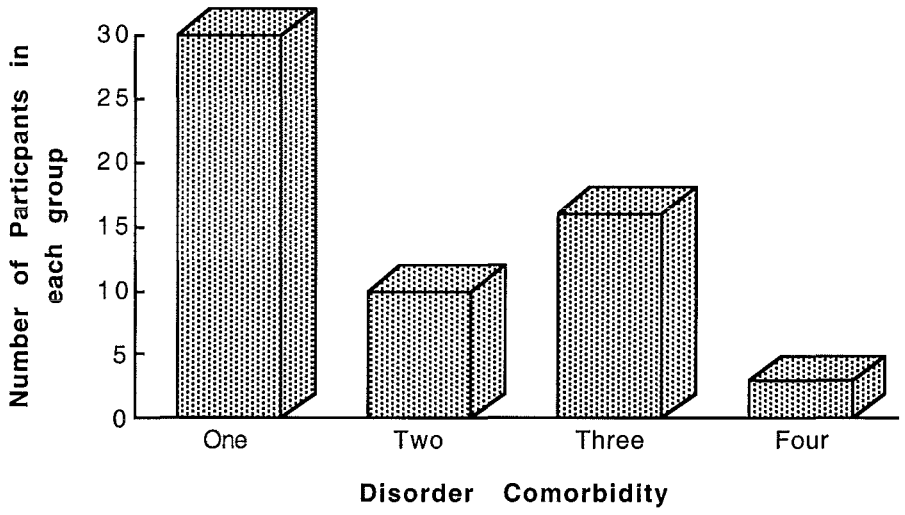


Figure 4. COMORBIDITY AND DISORDER TYPE AMONG THE PARTICIPANTS

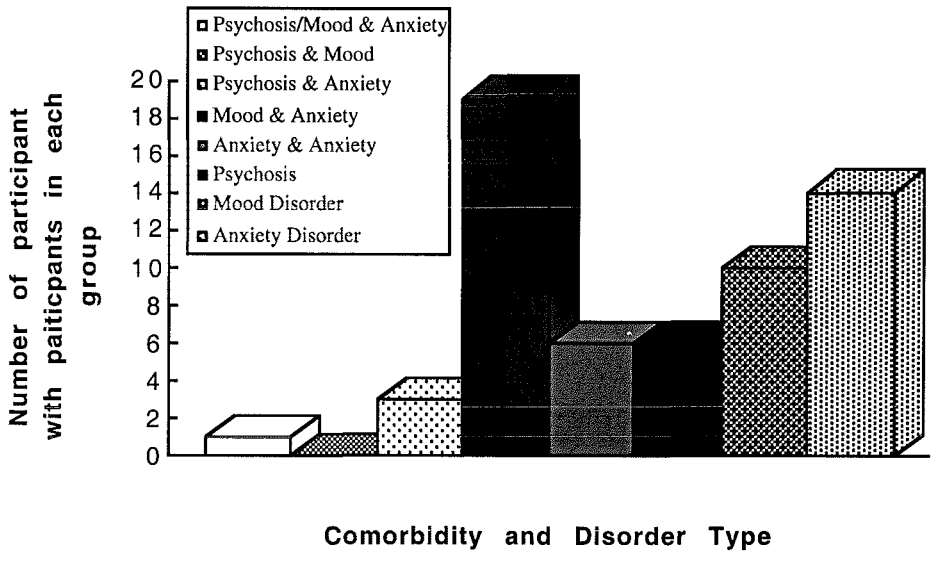


Table 5(b). **COMORBIDITY AND DISORDER TYPE AMONG THE PARTICIPANTS.**

Comorbidity	*Sample*	
Disorder Type	**N**	**Percent**
Psychosis & Mood & Anxiety (1 ≤)	01	1.7
Psychosis & Mood	00	0.0
Psychosis & Anxiety (1 ≤)	03	5.1
Mood & Anxiety (1 ≤)	19	32.2
Anxiety & Anxiety (1 ≤)	06	10.2
Psychosis Only	06	10.2
Mood Only	10	16.9
Anxiety Only	14	23.7
Total	**59**	**100.0**

3.3.3. THE PREVALENCE RATE OF DISORDER SEVERITY AMONG THE PARTICIPANTS.

As shown in Table 6(a). and Figure 5., the most frequent disorder severity rating was moderate (n=28). In total 18 participants had at least one mental disorder at the severe level, whereas only 13 prisoners had a mild mental disorder exclusively (one or more at this severity level).

Table 6(a). **THE NUMBER OF PRISONERS WITH A DISORDER AT EACH SEVERITY LEVEL (PRIMARY DISORDER ONLY).**

	Disorder Severity Level					
Participants	Severe		Moderate		Mild	
Number	N	Percent	N	Percent	N	Percent
Single Disorder	3	5.1	16	27.1	11	18.6
Comorbid Disorder	15	25.4	12	20.3	2	3.5
Total	**18**	**30.5**	**28**	**47.4**	**13**	**22.1**

The severity level and the type of mental disorder are presented in Table 6(b) and illustrated in Figure 6. An anxiety disorder at the moderate level of severity was the most prevalent disorder (n=21). A severe anxiety disorder was the second most common disorder

(n=15). There was an almost equal distribution of prisoners suffering from a moderate mood disorder (n=13) and a mild anxiety disorder (n=14). The moderate level of severity was the most prevalent for prisoners who had a psychotic disorder (50%).

Figure 5. THE NUMBER OF PARTICIPANTS WITH A DISORDER AT EACH SEVERITY LEVEL (PRIMARY DISORDER ONLY).

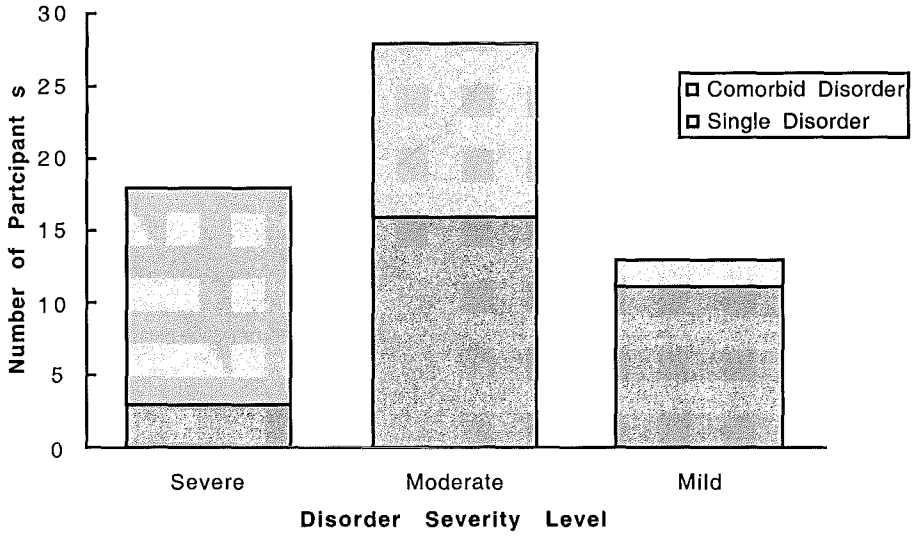


Figure 6. SEVERITY RATING AND DISORDER TYPE.

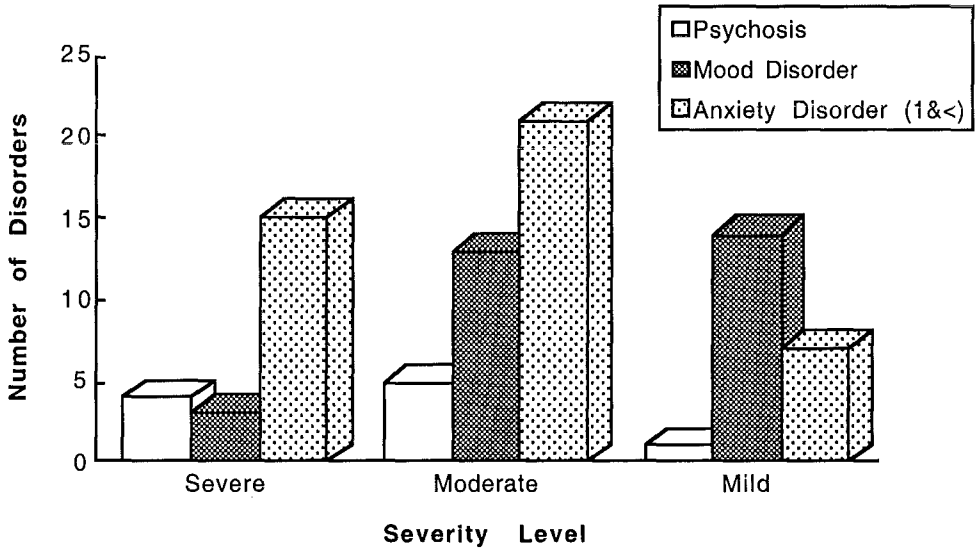


Table 6(b). **THE FREQUENCY OF TYPE OF DISORDER AND THE SEVERITY LEVEL AMONG THE MENTALLY DISORDERED PRISONERS.**

	Disorder Severity Level					
	Severe		Moderate		Mild	
Disorder Type	N	Percent	N	Percent	N	Percent
Psychosis	4	6.8	5	8.5	1	1.7
Mood Disorder	3	5.1	13	22.0	14	23.7
Anxiety Disorder(1 ≤)	15	25.4	21	35.6	7	11.9
Total	**22**	**37.3**	**39**	**66.1**	**22**	**37.3**

3.3.4. THE PREVALENCE RATE OF MDP WITH SUBSTANCE USE DISORDER COMORBIDITY.

Out of the 59 mentally disordered participants, forty eight had a comorbid substance use disorder. As shown in Table 7., the majority (44%) had a drug and alcohol problem, while eleven of the MDP did not suffer from a comorbid substance use disorder.

Table 7. **MENTAL DISORDER AND SUBSTANCE USE DISORDER COMORBIDITY.**

	Substance Use Disorder	
Type	N	Percent
Drugs and Alcohol	26	44.1
Drugs Only	17	28.8
Alcohol Only	05	8.5
Neither	11	18.6
Total	**59**	**100.0**

3.4. ASSESSMENT OF MDP' ACCESS TO MHT UNDER HUMANE CONTAINMENT PRINCIPLES.

To reiterate, participants with the current diagnosis of psychosis, mood disorder and/or anxiety disorder were categorised as MDP entitled to MHT under humane containment principles. According to this criteria, there were 59 MDP and 35 non-MDP from the total participant sample (n=94).

3.4.1. DETECTION (REFERRAL) ACCURACY RATE OF MDP.

It is equally important, with regard to the efficiency of the referral system, for mentally disordered and non-MDP to be detected appropriately (Refer to Figure 1.). Chi-square analysis showed that there was a significant relationship between group membership and appropriate detection, (χ_2 (1,94)=13.5, p=0.001). As shown in Table 8, only one non-MDP was erroneously referred for MHT (i.e. a false positive). However, 57.6% of the MDP were not detected as mentally disordered and subsequently not referred for treatment (i.e. false negatives). One by two chi-square analysis showed that accurate detection of non-MDP was significant (χ_2 (1,35)=31.11, p=0.0001), whereas the accurate detection of MDP was not significant (χ_2 (1,59)=1.37, ns). This means that the non-referral of non-MDP solely accounted for the significant association found between the four groups.

Table 8. **THE APPROPRIATE DETECTION OF MENTALLY DISORDERED AND NON MENTALLY DISORDERED PRISONERS.**

Referred for Mental Health Treatment	*Mentally Disordered*				
	Yes		No		
	N	Percent	N	Percent	χ_2[25]
Yes	25	42.4	01	2.9	
No	34	57.6	34	97.1	13.5***
Total	**59**	**100.0**	**35**	**100.0**	

3.4.2. FACTORS INVOLVED IN THE DETECTION OF MDP.

To validate the hypothesis that personality traits may be a factor in the detection process it was necessary to assess whether there was a significant difference between the four possible groups (i.e., detected MDP, non-detected MDP, detected non-MDP and non-

[25] ***p=0.001

detected non-MDP) and personality traits as measured by the TCI. As there was only one participant erroneously referred for MHT, this group (non-detected non-MDP) was dropped from the analysis. This part of the analysis is provided in appendix (d).

All basic demographics, current offence, current mental disorder, current substance use disorder, criminal history and mental health history variables were analysed using chi-square analysis, and one-way analysis of variance (where appropriate) to determine which variables significantly differentiated between MDP who were appropriately detected (group 1) and these who were not (group 2). Fourteen variables which fell under four categories, were found to significantly differentiate between the two groups (refer to Table 9). Multivariate analysis was performed using these fourteen variables to establish the predictive discriminative power of each factor. The discriminant function was found to discriminate significantly between groups (Wilks Lambda λ (14)=0.45, p=0.0002). When cases were re-entered into the function, 86.44% of the "grouped" cases were correctly classified. As Table 9. shows, personality traits had the most significant discriminative power. Co-operativeness, novelty seeking sub scale one, and self-directedness were the highest contributors in this analysis. High co-operativeness scores were found to significantly increase the chance of detection whereas high self-directedness and high novelty seeking sub-scale scores were found to have a significantly negative effect on detection. Harm avoidance was also found to significantly discriminate between groups where high scores on this scale were found to increase the likelihood of detection.

A record on file of a previous admission to a psychiatric hospital was shown to be the most significant historical variable. However, all five mental health history factors (refer to Table 9) were found to increase the likelihood of a referral to varying degrees, showing that mental health history recorded on file significantly influenced the referral process. The two variables relating to current substance use disorder were found to have a negative influence on detection. In other words, the analysis showed that current drug problems decreased the likelihood of detection. The variables measuring current mental disorder status showed comparatively low predictive power. Nevertheless, it was found that the more co-occurring disorders present and the higher the severity of a disorder the greater the likelihood of detection. However, the type of current mental disorder present was found to have a negative influence on detection.

Table 9. **VARIABLES THAT PREDICT DETECTION (REFERRAL) OF MDP.**

Variables	*Discriminant Function Co-efficient*
Personality Traits	
Cooperativeness (Total Scale)	.529
Self-Directedness (Total Scale)	-.506
Novelty Seeking (Sub-scale one)	-.471
Harm Avoidance (Total Scale)	.230
Mental Health History on File	
Previous Psychiatric Admission to Hospital	.270
Previous Suicide Attempt on File	.263
Court Report for Current Conviction	.221
Personality Disorder Diagnosis on File	.145
Psychiatric/Psychological Report on File	.043
Current Mental Disorder	
Mental Disorder Comorbidity	.212
Mental Disorder Severity	.151
Disorder Type	-.099
Current Substance Use (Non Alcohol)	
Drug Status	-.243
Drug Comorbidity	-.196

3.5. COMPARATIVE ASSESSMENT OF PRISONERS ACCESS TO MHT UNDER REINTEGRATION POLICY.

To recap, MHT is most commonly offered under reintegration policy to prisoners suffering from a substance use disorder; those who have committed a sexual offence and those who have committed a violent offence. The assessment of the detection and referral procedure for prisoners who required rehabilitative MHT was therefore limited to these three areas.

3.5.1. ACCURACY RATE OF PRISONERS REFERRED FOR REHABILITATIVE MHT.

Prisoners with a Substance Use Disorder. Out of the 94 participants, seventy seven (82.1%) reached the diagnostic criteria of the DSM III R for a current substance use disorder. Chi-square analysis showed that the relationship between group membership and appropriate detection was significant, (χ_2 (1,94)=11.70, p=0.001). As shown in Table 10, the majority of prisoners (71.4%) who required rehabilitative MHT for a substance use disorder were referred appropriately (i.e. true positives), whereas only four prisoners were inappropriately referred (i.e. a false positive). One by two chi-square analysis showed that accurate detection of prisoners with and without a substance use disorder were significant (χ_2 (1,77),=14.14, p=0.005) and (χ_2 (1,17),=4.76, p=0.05) respectively.

Table 10. **THE APPROPRIATE DETECTION OF PRISONERS WITH A SUBSTANCE USE DISORDER.**

Referred for Rehabilitative MHT	Substance Use Disorder				
	Yes		No		
	N	Percent	N	Percent	χ_2[26]
Yes	55	71.4	04	23.5	
No	22	28.6	13	76.5	11.70***
Total	**77**	**100.0**	**17**	**100.0**	

Prisoners serving a Current Sentence for a Sexual Offence.

Out of the 94 participants, twenty five prisoners (26.6%) were serving a current prison term for a sexual offence. Chi-square analysis showed that there was a significant relationship between group membership and appropriate detection, χ_2 (1,94)=41.09, p=0.0001. As shown in Table 11, no prisoners were inappropriately referred to rehabilitative MHT for sexual offence related issues (i.e. a false positive). However, just under half of the prisoners (44%) convicted for a sexual offence were not appropriately referred (i.e. false negatives). To reiterate, this means that there was no record of a referral to treatment for sexual offence related issues on file. One by two chi-square analysis showed that appropriate non-referral of prisoners serving a non-sexual offence was significant (χ_2 (1,69),=69, p=0.0001). However, the referral of prisoners serving a current sentence for a sexual offence was not significant (χ_2 (1,25),=0.36, ns).

[26] ***p=0.001

Table 11. **THE APPROPRIATE DETECTION OF PRISONERS SERVING A CURRENT SENTENCE FOR A SEXUAL OFFENCE**

Referred for Rehabilitative MHT.	Current Sentence is a Sexual Offence				
	Yes		No		
	N	Percent	N	Percent	χ_2[27]
Yes	14	56.0	00	00.0	
No	11	44.0	69	100.0	41.09****
Total	**25**	**100.0**	**69**	**100.0**	

Prisoners serving a Current Sentence for a Violent Offence.

Out of the 94 participants, seventy three prisoners (77.6%) were serving a current prison term for a violent offence (sexual offences included). Chi-square analysis showed group membership and appropriate detection was significant (χ_2 (1,94)=4.17, p=0.05). As shown in Table 12, only five prisoners were inappropriately referred to MHT (i.e. a false positive). However, just under half of prisoners (47.9%) who required rehabilitative MHT for a violent offence were not referred appropriately (i.e. false negative). Again, this means that there was no record of a referral to treatment for violent offence related issues on file. One by two chi-square analysis showed that appropriate non-referral of prisoners not serving a current sentence for a violent crime was significant (χ_2 (1,21),=5.76, p=0.03). However, the appropriate referral of prisoners serving a current sentence for a violent crime to MHT was not significant (χ_2 (1,73),=0.13, ns).

[27] ****p=0.0001

Table 12. **THE APPROPRIATE DETECTION OF PRISONERS SERVING A CURRENT SENTENCE FOR A VIOLENT OFFENCE.**

Referred for Rehabilitative MHT	Current Sentence is a Violent Offence				
	Yes		No		
	N	Percent	N	Percent	χ_2[28]
Yes	38	52.1	05	23.8	
No	35	47.9	16	76.2	4.17*
Total	**73**	**100.0**	**21**	**100.0**	

3.6. ASSESSMENT OF MHT DELIVERY UNDER HUMANE CONTAINMENT PRINCIPLES.

3.6.1. TREATMENT OFFERED TO ACCURATELY DETECTED MDP.

Out of the 59 MDP only 25 were appropriately referred to MHT. Treatment offered to the twenty five detected MDP is presented in Table 13. No significant relationship was found between accurate detection (i.e. referral) and treatment offered, (χ_2 (1,25)=0.05, ns).

Table 13. **TREATMENT OFFERED AND DETECTED MDP.**

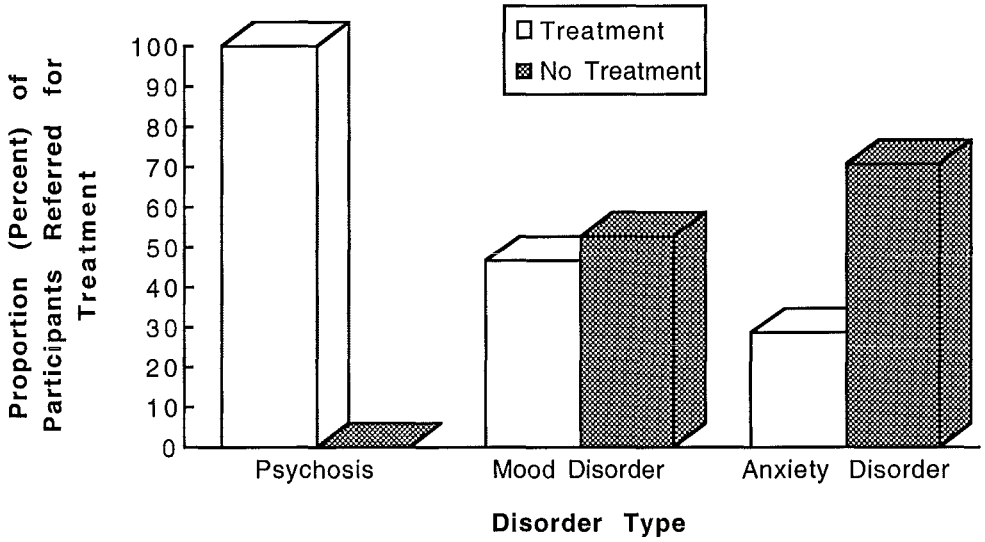
Treatment Offered	*Detected Mentally Disordered Prisoners*		
	N	Percent	χ2
Yes	12	48.0	
No	13	52.0	0.05
Total	**25**	**100.0**	

3.6.2. FACTORS PREDICTED TO INFLUENCE TREATMENT OFFERED TO DETECTED MDP.

The variables predicted to influence MHT offered to detected MDP are presented in Table 14 and are illustrated in Figures 7. to 12. To reiterate, the operational definition of a primary disorder in this research was the disorder with the most positive or overt symptoms for each disordered participants.

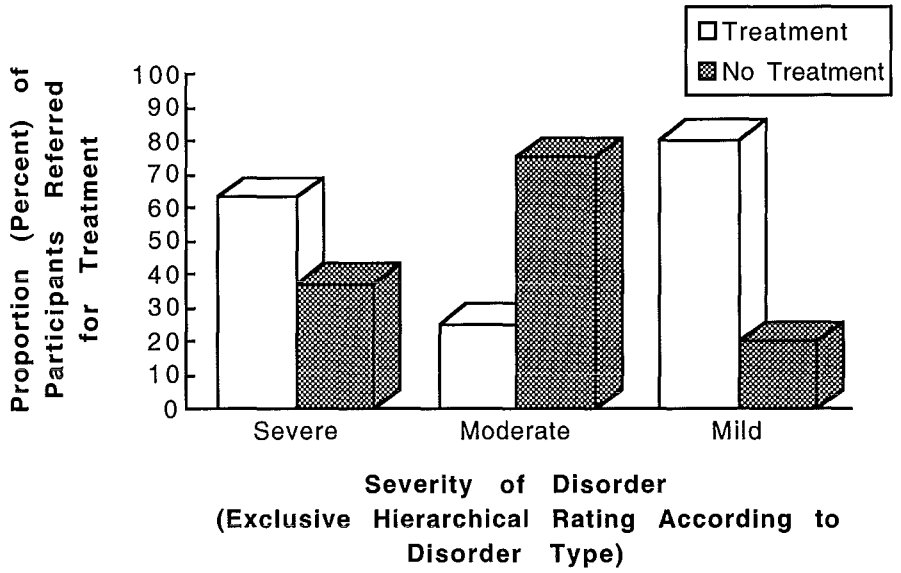
[28] *p=0.05

Figure 7. DISORDER TYPE AS A FUNCTION OF TREATMENT DELIVERY.



The primary disorder was used as the measure for the "disorder type" factor. It was found that the type of disorder present had no significant association with treatment offered, $\chi_2(2,25)=4.3$, ns. However, it should be noted that cell size for each group was small (refer Table 14.). Figure 7. highlights that there is a trend relating to the provision of treatment and the type of disorder present. All participants with psychoses who were detected were offered treatment. Approximately 50% of the detected participants with a mood disorder received treatment, whereas only 40% of those participants with an anxiety disorder who were referred were offered treatment. The number of co-occurring disorders were not found to have a significant association with treatment delivery, $\chi_2(3,25)=1.8$, ns. Yet again, cell size was small for each variable grouping, however, no apparent trend was found for disorder comorbidity (refer to Figure 9.).

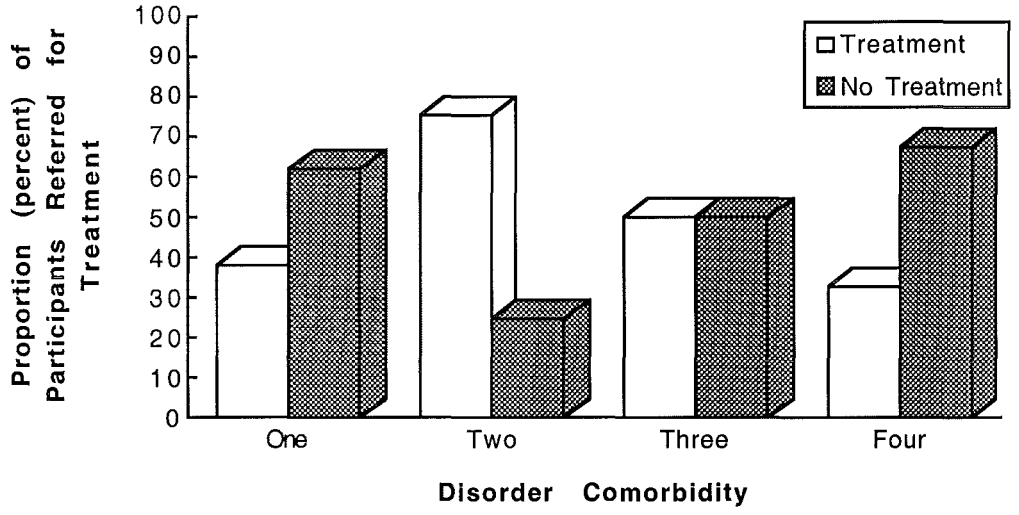
Figure 8. DISORDER SEVERITY AS A FUNCTION OF TREATMENT DELIVERY.



The highest severity rating of a current disorder, regardless of disorder type, was the measure used for the "comorbid disorder severity" factor. This variable was found to have a significant association with treatment offered, $\chi 2(2,25)=6.0$, $p=0.05$. Approximately 64% of detected participants suffering from a disorder at the severe level were offered treatment (refer to Figure 10.). A similar treatment response rate was found for detected participants who had a disorder at the mild severity level, where 66.7% were offered treatment. However, the majority of detected participants with a moderate rating were not offered treatment, where only 12.5% were offered treatment. Again cell size must be noted, especially with regard to the high treatment response rate for detected participants with a disorder at the mild level of severity ($\underline{n}=3$). The severity rating for each participant's primary disorder (ie, the disorder with the most positive or overt symptomatology) was not found to have a significant influence on

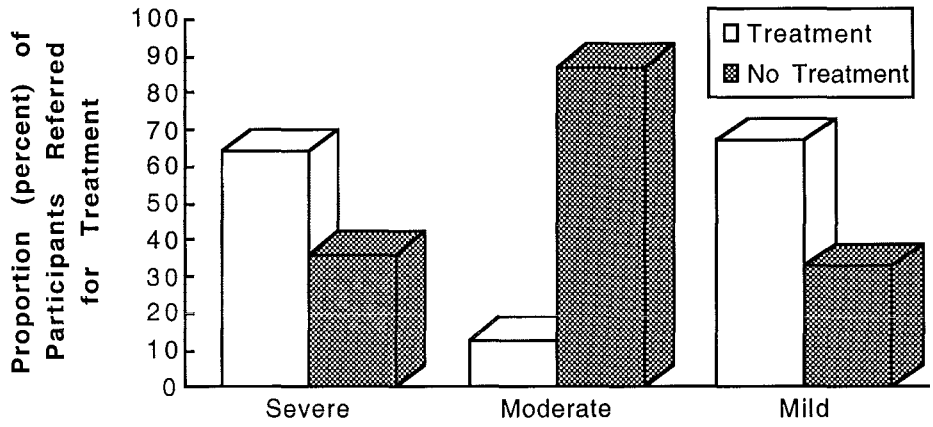
treatment delivery, $\chi_2(2,25)=5.3$, ns. However, it should be noted that cell size for each group was small (refer Table 14.). Figure 8. highlights that there may be a trend relating to the provision of treatment and the severity rating of the primary disorder. Sixty three percent of the detected participants with a primary severe disorder were provided with MHT whereas only 25% with a moderate primary disorder were offered MHT. However, 80% of the detected participants with a mild primary disorder were offered treatment.

Figure 9. DISORDER COMORBIDITY AS A FUNCTION OF TREATMENT DELIVERY.



Mental health history recorded on file was not found to have a significant association with MHT delivery, $\chi_2(2,25)=1.0$, ns. However, as shown in Figure 11., 60% had a record of at least one past hospital admission and only two of the 25 detected participants had no record of mental health history on file.

Figure 10. COMORBID SERVERITY AS A FUNCTION OF TREATMENT DELIVERY.



There was also no significant association found between substance use comorbidity and MHT delivery, $\chi_2(2,25)=3.7$, ns. Again, cell size was small which may have a bearing on this finding as there appears to be a trend present. As shown in Figure 12, 70% of the detected MDP with alcohol and drug use were offered MHT, whereas 43% with drug or alcohol use were offered MHT, and only 25% without substance use comorbidity issues were offered MHT.

As presented in Table 14., two personality traits were found to have a significant association with treatment delivery. Lower co-operativeness scores were found to increase the likelihood of MHT delivery, *t-test* (1,23)=-2.51, p=0.02, whereas higher novelty seeking (sub-scale one) scores were found to increase the likelihood of MHT delivery, *t-test* (1,23)=-2.37, p=0.03.

Figure 11. Mental Health History as a Function of MHT Delivery

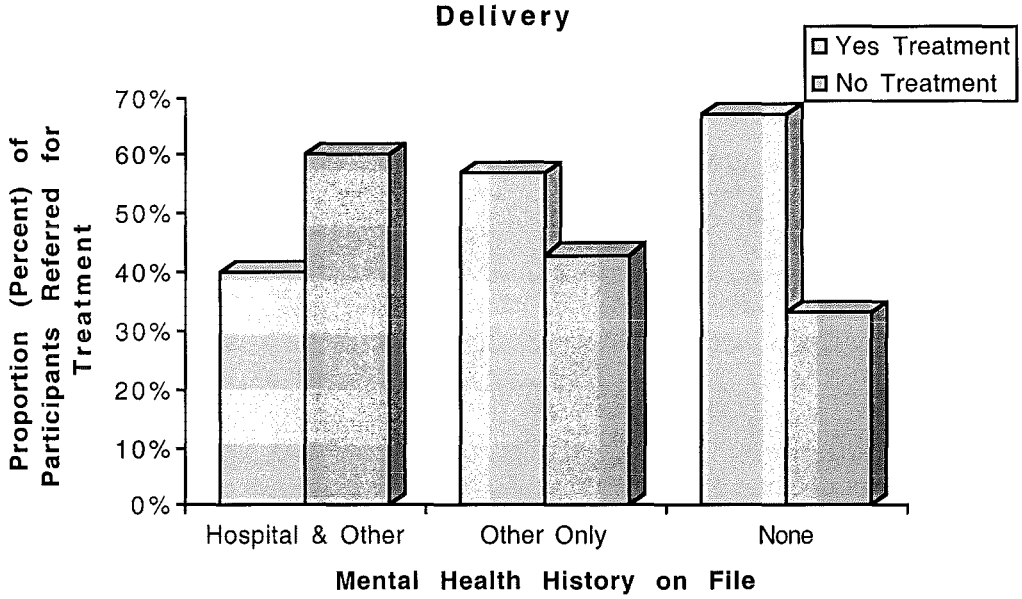


Figure 12. Substance Use Comorbidity as a Function of MHT Delivery

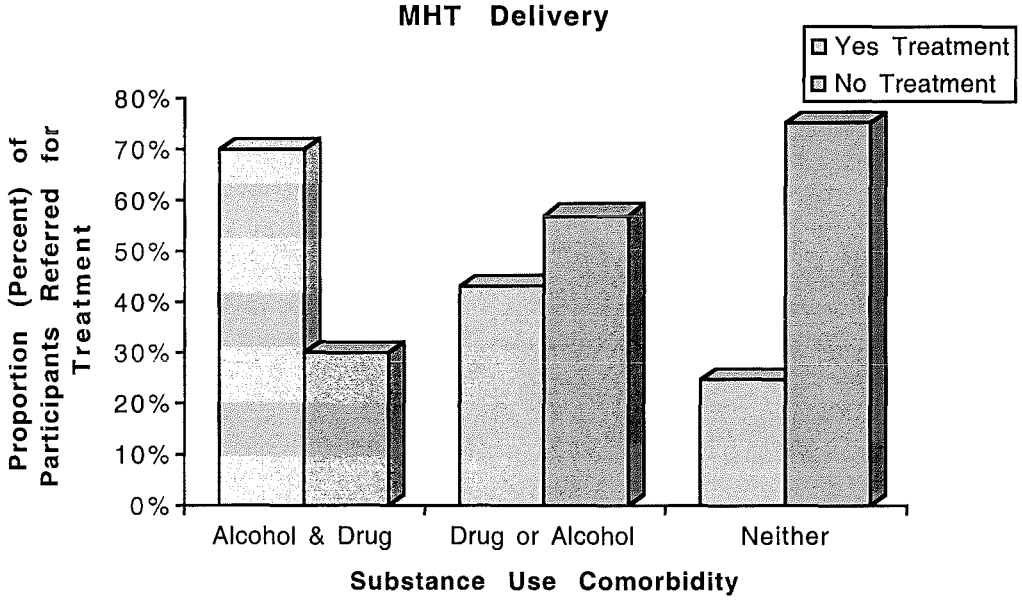


Table 14. **VARIABLES PREDICTED TO INFLUENCE MHT OFFERED.**

Treatment Offered	*Variables*			
	Disorder Type			
	PSYCHOSIS	**MOOD DISORDER**	**ANXIETY DISORDER**	$\chi 2$[29]
YES	3	7	2	
NO	0	8	5	4.3
	Disorder Severity			
	SEVERE	**MODERATE**	**MILD**	
YES	5	3	4	
NO	3	9	1	5.3
	Disorder Comorbidity			
	4	**3**	**2**	**1**
YES	1	5	3	3
NO	2	5	1	5
	Comorbid Disorder Severity			
	SEVERE	**MODERATE**	**MILD**	
YES	9	1	2	
NO	5	7	1	6.0*
	Mental Health History on File			
	HOSPITAL & OTHER	**OTHER ONLY**	**NONE**	
YES	6	4	2	
NO	9	3	1	1.0
	Substance Use Comorbidity			
	DRUG & ALCOHOL	**DRUG OR ALCOHOL**	**NEITHER**	
YES	7	3	2	
NO	3	4	6	3.7
	Personality Traits			
	CO-OPERATIVENESS			
	M	**SD**		*t-value* [30]
YES	23.3	5.5		
NO	29.2	6.4		-2.5*
	NOVERTY-SEEKING (SUB-SCALE ONE)			
	M	**SD**		*t-value*
YES	4.6	1.7		
NO	5.9	1.1		-2.4*

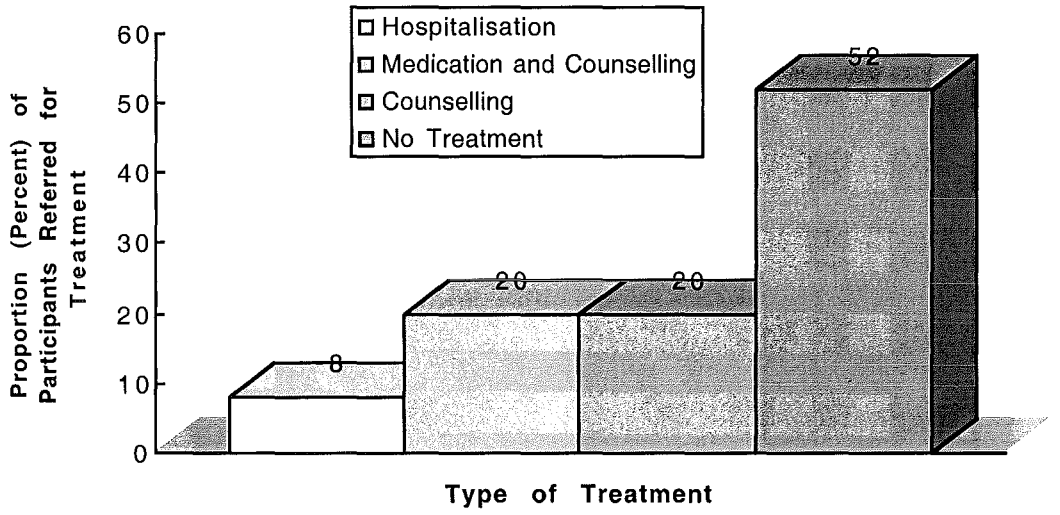
[29] *p=0.05

[30] *P=0.05>0.01

3.6.3. TYPE OF TREATMENT OFFERED TO DETECTED MDP.

The type of treatment offered to detected MDP (n=25) is presented in Figure 13. Just over half (52%) of the MDP who were appropriately detected and thus referred did not receive any form of treatment. Counselling with medication and counselling only were equally common treatment responses. Only two detected participants were hospitalised for the provision of treatment.

Figure 13. TYPE OF TREATMENT OFFERED TO MENTALLY DISORDERED PRISONERS.



3.7. COMPARATIVE ASSESSMENT OF MHT OFFERED UNDER REINTEGRATION POLICY.

3.7.1. TREATMENT OFFERED TO APPROPRIATELY REFERRED PRISONERS.

Treatment Offered to Prisoners with a Substance Use Disorder. Out of the 77 prisoners with a substance use disorder, 71.4% (n=55) were appropriately referred for rehabilitative MHT. Treatment delivery for these prisoners is presented in Table 15. Chi-square analysis showed that there was no significant relationship

between accurate detection, thus a referral, and the delivery of treatment, (χ_2 (1,55),=0.45, ns).

Table 15. **TREATMENT OFFERED AND SUBSTANCE USE DISORDER DETECTION.**

Rehabilitative MHT Offered	Detected Prisoners with Substance Use Disorder		
	N	Percent	$\chi 2$
Yes	25	45.5	
No	30	54.5	0.45
Total	**55**	**100.0**	

Treatment Offered to Prisoners serving a Current Sentence for a Sexual Offence. Out of the 25 prisoners serving a current sentence for a sexual offence, 56% (n=14) were appropriately referred for rehabilitative MHT. Treatment delivery for these fourteen prisoners is presented in Table 16. Chi-square analysis showed that there was no significant relationship between accurate detection and treatment offered, (χ_2 (1,25),=1.14, ns).

Table 16. **TREATMENT OFFERED AND SEXUAL OFFENCE DETECTION.**

Rehabilitative MHT Offered	Detected Sexual Offence Prisoners		
	N	Percent	$\chi 2$
Yes	09	64.3	
No	05	35.7	1.14
Total	**14**	**100.0**	

Treatment Offered to Prisoners Serving a Current Sentence for a Violent Offence. Out of the 73 prisoners who were serving a current sentence for a violent offence, 52.1% (n=38) were appropriately referred for rehabilitative MHT. Treatment delivery for these prisoners is presented in Table 17. Chi-square analysis showed that there was no significant relationship between an appropriate referral and treatment delivery, (χ_2 (1,38),=0.00, ns).

Table 17. **TREATMENT OFFERED AND VIOLENT OFFENCE DETECTION.**

Rehabilitative MHT Offered	Detected Violent Offence Prisoners		
	N	Percent	$\chi 2$
Yes	19	50.0	
No	19	50.0	0.00
Total	**38**	**100.0**	

Chapter Four

DISCUSSION OF RESULTS

To recap, this current inquiry sought to empirically investigate the humane containment of MDP. There is a dearth of scientifically based research found across western countries in this area and this type of research has not previously been undertaken in this country. In light of the general trend in the social climate found across several western nations, empirical based research such as this is imperative to substantiate the validity of information obtained through observational and survey research methods, which constitute the majority of the available literature. Furthermore, while humanitarian concern regarding the plight of MDO has been the primary impetus behind the recent growth in interest in this area, there has been an absence of uniformity in the research perspectives underpinning such investigations. Because the protection of MDP' human rights constitutes the fundamental point of concern in this regard, *prisoners' rights* functioned as the framework for the current research.

More directly, the research reported in this thesis specifically sought to ascertain whether there is a gap between MDP' paper and practical right to MHT in NZ. This involved the establishment of a estimated base rate of MDP and a three-tiered examination of the operational detection and referral procedure, and of the treatment delivery system. Eight hypothesises were generated in light of the available literature and were largely supported, suggesting that there is a substantial gap between MDP' legal entitlements to MHT

and the practical fulfilment of such entitlements. These findings have important implications for penal reform and future research.

4.1. ESTIMATED BASE RATE OF MENTALLY DISORDERED PRISONERS.

The primary consideration of this research was the humane containment of MDP and the first objective was to establish an estimated base rate of MDP in NZ, who had a current disorder which fell within the legal parameters of prisoners' entitlement to MHT under human containment principles. The randomised sample of this study was relatively large in terms of the existing literature, constituting approximately 50% of medium security inmates at Christchurch Men's Paparua Prison. The descriptive data showed that this sample was a good representation of the NZ national male prison population. This means that it is reasonably safe to generalise the current findings to the broader prison context in this country. Moreover, the SCID was utilised to evaluate current mental health status, which means that the DSM-III-R diagnostic criteria functioned as the operational definition of a mental disorder. This validates the substantiality of the current findings, as the SCID is a standardised assessment and the DSM-III-R was the major diagnostic system of mental disorders at the time.

It was found that 62.8% ($\underline{n}$ = 59) of the participants had at least one current mental disorder in accordance with the DSM-III-R criteria. This present base rate is at the upper end of the broad range (0.5% to 80%) of prevalence estimates reported across western countries (Prins, 1993). As mentioned in section 1.5, this wide variation is primarily due to methodological inconsistencies such as the definitional criteria of a mental disorder and the type

of penal institution perused. It is widely held that more mentally disordered persons reside in jails/remand centres rather than prisons. Higher prevalence estimates have also been related to and trivialised because mental disorders or mental health problems commonly associated with offending behaviour have often included. On the other hand, lower prevalence estimates have commonly been associated with very restrictive definitional criteria, most notably chronic mental illness (Bartol, 1991; Hodgins, 1995; Prins, 1993). Clearly, this presents certain difficulties for directly comparing the current findings. However, the current findings show that when typical offence related mental health problems are excluded from the definitional criteria and the operational definition of a mental disorder is strictly clinically based and legally bound, there appears to be a substantial proportion of mentally disordered persons residing in prison, far outweighing rates found in the general population. The current finding is approximately four times higher than indirect NZ estimates, which concur with findings by Hodgins (1995) and Ogloff et al (1993) that higher prevalence rates are generally obtained with the use of standardised assessments as opposed to survey methods. Given the operational criteria of the current study, it is likely that this relatively high base rate is a measure of the "unknown" group of MDP Prins (1993) refers to, supporting the growing speculation that there are more mentally disordered persons residing in prisons than present estimates suggest. Clearly this current finding supports the first hypothesis and affirms that there is a significant proportion of clinically mentally disordered persons residing in prison who are entitled to MHT under humane

containment principles according to the current research framework.

Disorder Severity. The severity of a mental disorder is indicative of the immediacy for detection and treatment. In the current study it was found that 30.5% of the disordered participants had at least one current disorder at the severe level. Again this finding is somewhat difficult to compare with other research findings, primarily because the majority of investigations have focused on the prevalence of chronically mentally ill inmates, especially those who fall under the definitional criteria of mentally disordered under mental health legislation. In the current study 6.8% of the mentally disordered participants fell within this criteria. This is consistent with indirect estimates reported by NZ prison staff (NZ Ministry of Health, 1987) and also concurs with estimates reported in England (Prins,1993), the US, and Canada (Hodgins, 1995). Therefore, this finding validates indirect NZ estimates and supports the claim that, in line with other western countries, in NZ there is a small yet significant proportion of MDP who require access to institutional psychiatric treatment while serving their prison-term. Although only a small proportion of the disordered inmates in the current study were considered eligible for hospital care, this is not to say that such persons were offered this form of treatment. More pertinently, the majority (24%) of these severely disordered participants were considered unlikely to meet such criteria. Although this current finding is difficult to directly compare with previous estimates, it was found that just under a third of the MDP had a severe mental disorder which is consistent with available report findings despite methodology

variation (Prins, 1993; Wardlaw, 1986). Manifestly, this finding validates the claim that there is a significant number of MDP who are severely disordered and require immediate MHT, and also supports the view that the provision of institutional treatment, whether community or penal based, is likely to be insufficient to cater adequately for severely disordered offenders residing in penal custody. Disorder severity is undeniable a major consideration in treatment prioritisation, however, this does not negate the importance of identifying and treating prisoners suffering from pertinent clinical disorders at all levels of severity. In the current study it was found that 47.5% of the disordered participants had a mental disorder at the moderate level of severity, while the remaining 22% had a disorder at the mild severity rating. This finding indicates that there is a sizeable proportion of MDP who are at risk of further decomposition while incarcerated. Manifestly, this finding affirms that narrow focus on the chronically mentally ill is misguided and supports the view that the provision of preventative treatment measures would be an appropriate objective for the MHS system for this population.

Disorder Type. In the current study it was found that 16.9% of the mentally disordered participants had psychosis, which is congruent with Dvoskin and Steadman's (1989) research where it was reported that approximately 15% of the inmate sample were "seriously" psychiatrically disabled. It also corresponds with the general range (10% to 20%) of inmates suffering from a major disorder reported across other western countries (Hodgins, 1995; Jemelka et al., 1993; Prins, 1993; Wardlaw, 1986). In other words,

this finding scientifically reinforces the postulation that there is a significant number of offenders in custody with serious psychiatric problems in this country. The findings of the present study also showed that 50.8% of the participants had a current mood disorder, which is in line with Gunn et al (1978), who found that major depression amongst prison inmates was prevalent. While depression is not the only factor involved in suicide it is a common precipitator. Manifestly, these findings may in part explain the high rate of prison suicides consistently reported across western countries, including NZ (Prins, 1993; NZ Ministry of Health, 1987). As discussed in section 1.4, research by Zamble and Porporino (1988) investigating inmates and depression has been utilised to support the supposition that "depression" is to be expected at admission and likely to dissipate once inmates have adjusted. However, in the current study, the randomly selected participants were at varying points of their prison term when the screening interviews took place. The majority of the prisoners were mid-way through serving their sentence, which means that depressive symptoms relating to the initial adjustment to imprisonment was not likely to be a prominent factor in this sample. This finding supports Rice and Harris's (1993) view that there is likely to be a number of inmates who require intervention for the amelioration of depressive symptoms while serving their sentence. Therefore, this finding suggests that there are more prisoners with clinical depression than proposed in the available literature and it also validates current endeavours to provide this type of treatment for this population. As discussed in section 1.4 and 1.5, less "obvious" disorders with predominantly covert symptomatology, such as anxiety disorders, have received little

attention in this area. However, it was found in the current study that approximately 73% of the participants had at least one anxiety disorder, which is consistent with Wormith et al (1988) research, who found that anxiety levels were relatively high for a significant proportion of inmates. This finding adds further support to Hilkey's (1988) assertion that the prison environment increases inmates' vulnerability to psychological stress, especially in overcrowded conditions. This current finding, however, suggests that the level of psychological stress is likely to be more debilitating than current speculations imply, given the number of participants found to have a clinical anxiety disorder.

Comorbidity Issues. Disorder comorbidity has not largely been an issue explored in this area, however, one of the most compelling prevalence findings in this research is the high proportion of MDP with co-occurring disorders. Almost half of the disordered participants were found to have a co-occurring clinical disorder other than substance use disorder and 81.4% were found to have substance use comorbidity. This finding is congruent with Scandrett's (1988) NZ research, where she found that the majority of the female inmates assessed had more than one clinical disorder, which is in line with literature from other western countries, where a significant proportion of inmates have been reported to have co-occurring disorders including substance use disorder (Côté and Hodgins, 1988; Hodgins, 1995; Peters & Hills, 1993; Porporino and Motiuk, 1995). This relatively high rate of MDP with co-occurring disorders means that such persons may be more vulnerable than other mentally disordered persons to incarceration in this country, which concurs with overseas

research, where it has been found that mentally disordered persons with multiple mental health issues, especially whose with substance use, appear to be more vulnerable to residing in penal custody (Belcher, 1988; Pogrebin & Poole, 1987; Schellenberg, et al, 1992). Clearly, these findings support Peters and Hills' (1993) view that more MHT programmes designed for mentally disordered persons with co-occurring substance use issues are required for the penal population. However, these current findings also show that substance use is not the only comorbidity issue for a significant proportion of MDP, which indicates that the need for comprehensive MHT programmes is not just limited to the issue of substance use comorbidity.

In sum, the base rate estimate obtained in the present research is congruent with indirect NZ data and also concurs with prevalence rates reported in other western countries. These findings directly and scientifically support the postulation that the containment of mentally disordered persons in penal custody in NZ is likely to emulate other western nations. More specifically, the relatively high percentage of participants found to have at least one clinical disorder, scientifically supports the speculation that there are likely to be more MDP than presently theorised, supporting the first hypothesis. It should be acknowledged that, while the majority of the inmates were found to have less salient clinical disorders at the moderate level of severity, all 59 MDP in this study are arguably morally and legally entitled to the access to MHT under humane containment principles, regardless of severity. Clearly, the current research findings substantiate that there is likely to be a significant proportion of prisoners in NZ who are

entitled to MHT under humane containment principles, making the provision of such services a pressing human rights issue. The relatively high proportion of MDP found to have co-occurring disorders, especially substance use comorbidity, affirms that a comprehensive MHS system is essential within the NZ prison service for the protection of such persons' fundamental rights.

4.2. THE DETECTION AND REFERRAL PROCEDURE.

To recap, the second objective was to quantify the detection and referral procedure currently in operation at Christchurch Men's Paparua Prison to ascertain whether or not the identification system functioned in a manner necessary for the fulfilment of MDP' entitlements. This involved the detailed analysis of three aspects of this system for which corresponding research hypothesises were yielded.

4.2.1. THE DETECTION AND REFERRAL OF MDP.

The first aim of the second objective was to quantify the accuracy rate of the detection and referral of MDP. The second research hypothesis was that the detection/referral rate of MDP would be quite low. The current findings show that the operational identification system was efficient at appropriately not referring non-MDP, as there was only one such participant erroneously referred (i.e., one false positive). In other words, it was found that in general only prisoners who required MHT were referred, which indicates that correctional staff have some insight into psychopathology and also suggests that this system functions appropriately to some degree. However, it was also found in the current study that the majority of MDP were not referred for MHT.

In fact, it was found that there was a low likelihood of being appropriately referred for MHT, which indicates that the identification system in operation at Paparua Prison is not providing MDP with adequate access to MHS and is therefore not effectively protecting such persons' entitlement to MHT. This current low detection and referral rate concurs with the general literature pertaining to the operational identification system in penal institutions (Ogloff et al, 1993; Steadman, et al, 1989). It is also congruent with research by Holley and Arboleda-Florez (1988) and Teplin and Pruett (1992) on the police referral of MDO, where it was found in both studies that there was a significant discrepancy between the presence of a mental disorder and a referral to MHS. More directly, in the present study it was found that only 25 out of the 59 MDP were appropriately detected and referred, which means that 57.6% of the inmates with a current mental disorder were unlikely to have access to treatment as they were not detected/referred for MHT. This is congruent with research by Teplin (1990), who found that 62.5% out of 40 severely ill detainees went undetected. Clearly, this finding supports the second research hypothesis that the detection and referral rate of MDP would be reasonably low and also concurs with findings from other western countries. Although it is reported that there is variation in the individual management of penal institutions across several western countries, including NZ, given the legislative and policy requirements in this regard the current findings are likely to reflect the general efficiency of the detection and referral process employed in prisons across this country. This means that there is likely to be a comparatively low detection rate of MDP throughout NZ, which supports the assertion that the current

identification process, which is rudimentary to MDP' access to MHS, limits such access. Therefore, in accord with other western countries, a reasonable number of MDP is likely to go undetected in the NZ prison system, placing such persons at risk of human right infringements.

4.2.2. FACTORS PREDICTED TO INFLUENCE DETECTION AND REFERRAL.

The second aim of the second objective was to ascertain whether certain variables influenced the detection and referral process, which was evaluated using multivariate analysis. In accordance with the available literature it was hypothesised that five generic factors would be involved in this process (refer to sub-section 3.4.2.).

Personality Traits. Supporting the third research hypothesis, personality traits, as measured via the TCI, were found to discriminate significantly between detected and non-detected MDP. In fact, three out of the four personality traits examined were found to be the most powerful discriminatory variables. Co-operativeness was found to have a positive influence on detection where higher co-operativeness scores were found to increase the likelihood of detection and a referral. This personality trait was found to have the most influence on detection. While disruptiveness is not an exact opposite of co-operativeness, as measured via this scale, this finding appears to be in contrast with the widely held view that disruptive behaviour is positively associated with a referral for MHT (Adams, 1986; Bartol, 1991; NZ Department of Justice, 1981 Prins, 1993). This finding indicates that when the identification system is perused more holistically, co-operativeness stands out as a positive factor, rather than

disruptiveness, which suggests that the latter may actually decrease the likelihood of detection. Therefore, this finding supports that assertion that management issues are not a dominant factor in the identification system and also suggests that the focus on the chronically mentally ill, who are more likely to exhibit disruptive behaviour, may skew the findings in this regard. The second most influential personality trait was novelty seeking (sub-scale one), where higher scores were found to decrease the likelihood of detection. In other words, MDP who exhibited typical "criminal" personality traits, as measured via the novelty seeking scale, were less likely to be appropriately detected and referred for MHT. This finding concurs with Hodgins and Côté's (1993) findings that MDP without typical criminal characteristics stood out from the general prison population. Therefore this finding supports the postulation that "atypical" inmates are more likely to come to the attention of correctional staff, increasing the chance of detection.

Self-directedness and harm avoidance were the remaining two personality traits found to have an influence on detection. Higher self-directedness scores were found to decrease the likelihood of a referral whereas higher harm avoidance scores were found to increase the likelihood of a referral. These findings suggest that the identification process is sensitive to psychopathology to some degree, as self-directedness is indicative of normative social functioning whereas harm avoidance has been associated with psychopathology. In other words, this finding indicates that correctional staff are aware of the fundamental elements of mental disorders, which is consistent with results reported by

Toch and Adams (1988), who found that there was considerable agreement between correctional and forensic staff regarding pathological behaviour of inmates. While it is somewhat difficult to compare these findings directly with overseas research, it is apparent that personality traits were found to have a significant influence on detection, which supports the third hypothesis.

Mental Health History On File. All mental health history factors (refer to sub-section, 3.4.2) were found to have a significant influence on detection to varying degrees, where a previous admission to hospital and a previous suicide attempt recorded on file were found to be the most significant factors. In other words, it was found that MDP with mental health history recorded on file were more likely to be detected and appropriately referred. This finding is congruent with research by Teplin (1990) and by Aubrey (1988), where it was found in both studies that mental health history was positively associated with detection. This finding also concurs with the peruse of the identification system by Steadman et al (1989) and by Ogloff et al (1993). In both these investigations it was found that recorded mental health history was commonly utilised to "flag" inmates who may require MHT. Clearly, this finding supports the third research hypothesis and indicates that in NZ, as found overseas, recorded mental health history is utilised as a means of detection.

Current Mental Disorder. The three current mental disorder factors that were examined were found to have some discriminatory power. Out of these three factors, mental disorder comorbidity was found to have the most influence on detection. In other words, it was found that detection was more likely the more co-occurring

disorders a prisoner had (excluding substance use comorbidity). While mental disorder severity had less predictive power, this variable was found to have a similar influence on detection, where the likelihood of detection was found to increase as the severity rating of a disorder increased. Type of mental disorder had the least influence on detection out of the current mental disorder factors, where this variable was found to have a negative impact on detection. This latter finding is not congruent with the literature and it does not support the research hypothesis. However, this factor's lack of predictive power is most likely due to the high rate of disorder comorbidity found within the sample, which obscures both the type and severity of the individual clinical disorders. Clearly the inclusion of comorbidity issues and the separate assessment of severity makes it difficult to compare these findings directly. Nevertheless, it was found that current mental health status comes into play in the detection and referral process, which is consistent with the literature. Given that severity had a positive association with detection, it is likely that the participants with more co-occurring disorders displayed more visible signs of psychopathology, supporting the hypothesis that overt symptomatology or disorder type is likely to be a factor in detection. This concurs with the research finding that overt symptomatology or the presence of positive symptoms increases the likelihood of detection and/or a referral (Aubrey, 1988; Steadman et al, 1989; Teplin, 1990). These current findings partially support the research hypothesis and suggest that in the identification process disorder severity and comorbidity may be more important than disorder type, yet the presence of overt symptomatology appears to be involved.

Current Substance Use Disorder. Drug status and drug comorbidity were found to have a negative influence on detection, where MDP with drug related issues were found to be less likely to be detected and referred for MHT. These findings support the research hypothesis and are in line with Pogrebin and Poole (1987) and Hodgins (1995) where it was reported that persons with comorbid drug and/or alcohol problems were less likely to receive treatment at pre-sentencing level. The current finding suggests that similar principles may be in operation in the prison system as those found in the community. In other words, drug and alcohol problems appear to overshadow MDO need for humane containment based MHT. This finding suggests that the presence of alcohol and drug problems may be taken as a typical criminal characteristic in this process, which raises some concern given the fact that it is widely acknowledged that "self-medication" is a common problem experienced by disordered persons.

In sum, the third hypothesis was generally supported as all five generic factors were found to influence the detection and referral process to some degree. It is important to note that the strength of the personality traits may in part be due to the fact that the TCI was designed to predict persons vulnerable to mental health problems. The results suggest that this inventory did tap into the fundamental elements of psychopathy, which may explain why current and past mental health issues were not found to have more influence on detection. Therefore, while these findings are somewhat difficult to compare with overseas research, when the discriminating variables are considered collectively, it is apparent that the visible degree of psychopathology was found to be a factor

in the detection process which concurs with the literature. The current findings indicate that the "profile" of a MDP most likely to be detected is an inmate who has atypical criminal characteristics, is co-operative rather than disruptive, has mental health history on file, and has visible symptoms of psychopathy. This finding is in line with research evidence reported from other western nations and supports the general view that crisis intervention is a central element in the detection and referral process.

4.2.3. COMPARATIVE ASSESSMENT OF DETECTION FOR REHABILITATIVE MHT.

To recap, the secondary consideration of this research was the provision of rehabilitative MHT for prisoners. Therefore, the third and final aim of the second objective was to quantify the detection and referral process for rehabilitative MHT at Paparua Prison to compare prisoners' access to rehabilitative MHT with MDP' access to MHT. This analysis was limited to three common rehabilitative needs (i.e., alcohol and drug issues, sexual offence issues, and violence offence issue), and involved the assessment of the detection/referral rate. Pertinent to this part of the analysis was the fourth research hypothesis, which held that the accuracy rate of detection and a referral for rehabilitative MHT would be better than the detection and referral rate for MDP.

Supporting the fourth hypothesis, the referral of prisoners with a substance use disorder for rehabilitative MHT was found to be statistically significant. In other words, 71.4% of the participants with a substance use disorder were found to be appropriately referred for MHT, which indicates that the detection and referral process was found to be reasonable efficient for this type of issue.

More directly, this accuracy rate of appropriate referrals as compared to the rate found for MDP, concurs with the available literature, insofar as there commonly appears to be an emphasis placed on the assessment of criminogenic issues across countries. However, the appropriate referral to rehabilitative MHT for sexual offence related issues or for violent offence related issues was not found to be statistically significant. In other words, the provision of an appropriate referral was not found to be beyond the level of chance for these two groups, which does not support the fourth hypothesis. However, it should be noted that the size of these two groups was somewhat smaller than the substance use disorder group. When the raw data is perused it is apparent that slightly more participants were appropriately referred in both groups, which suggests that if a larger sample were employed a significant result may be obtained. In other words, the detection and referral process for criminogenic needs may be more efficient than the current findings indicate. This postulation is supported by the finding that the detection and non-referral of participants who did not require MHT under these three rehabilitative categories was statistically significant, which suggests that this process has some level of efficiency. Nevertheless, the present results show that a referral for rehabilitative MHT was only significant for participants with a substance use disorder, which only partially supports the research hypothesis. This suggests that prisoners' access to rehabilitative MHT, other than substance use treatment, is likely to be limited due to the current detection and referral process for criminogenic needs, which is in contrast with the findings from the available literature.

4.3. THE TREATMENT DELIVERY SYSTEM.

To reiterate, the third objective was to quantify the treatment delivery system currently in operation for prisoners at Christchurch Men's Prison Paparua. The purpose of this analysis was to ascertain whether or not the provision of MHT is sufficient for the protection of MDP's human rights. This inquiry involved the detailed analysis of four aspects of this system for which research hypothesises were yielded.

4.3.1. THE DELIVERY OF TREATMENT.

The first aim of the third objective was to quantify the accuracy rate of treatment delivery for MDP. In light of the available literature the fifth hypothesis was that the delivery rate of treatment would be reasonably low. This hypothesis was supported as the rate of treatment delivery was found to be below the level of chance where just under half of the detected mentally disordered participants were appropriately offered treatment. In other words, the delivery rate for detected MDP was statistically found to be the equivalent of the random provision of treatment. What this means is that the MHS system in operation was not found to cater adequately for MDP, supporting the view that this sub-group of offenders is extremely vulnerable to human rights infringements. While there is a lack of empirical research in this area, this result is not unexpected given the available literature on service provision. As discussed in section 1.7., when the provision of treatment is perused as opposed to the availability of services, it appears that there is a serious dearth of treatment delivery for this group of mentally disordered persons. This research empirically validates the information obtained via survey based

literature and indicates that the current system is not effectively protecting such persons' entitlement to MHT. Again, while it is reported across western countries that there is variation in the individual management of penal institutions, it is likely that the current findings reflect the general efficiency of the treatment delivery system in operation in prisons across this country. This means that in line with other western countries, there is likely to be a comparatively low rate of treatment offered to MDP throughout NZ.

4.3.2. FACTORS INVOLVED IN TREATMENT DELIVERY.

The second aim of the third objective was to ascertain if certain variables influenced whether or not treatment was offered. In accordance with the available literature, the sixth hypothesis was that current disorder factors, mental health history and personality traits and substance use would be involved in this process. To reiterate, multivariate analysis was not applicable for this part of the research due to the small proportion of participants offered treatment.

Current Disorder Factors. Given the emphasis in the legislation and under policy on disorder type it was hypothesised that this factor would have a positive influence on treatment delivery. However, neither disorder type nor disorder comorbidity were found to have a significant association with treatment delivery, which is in contrast with the literature and the current findings to date. While the issue of co-occurring disorders has not widely been investigated in relation to treatment delivery, this factor was found to be a significant variable in the detection and referral process in the current research, yet there appears to be no

relationship in regard to treatment delivery even when sample size is taken into consideration. Although disorder type was not found to be a statistically significant factor, when the raw data is examined there does appear to be an association between treatment offered and disorder type. All the detected participants with psychosis were offered treatment whereas only around half those with mood disorder and around a third of those with an anxiety disorder were offered treatment. This trend is consistent with the research findings that severely disordered offenders, most notably those with psychosis, are more likely to be offered treatment (Aubrey, 1988; Dell & Smith, 1983; Teplin, 1990). This means that with a larger sample a significant result may have been obtained. What the current findings show is that disorder comorbidity appears to be a more significant factor than disorder type in the detection process, where the reverse appears to be the case for the provision of MHT. This difference concurs with Toch and Adams' (1988) research comparing the approach of correctional and mental health staff toward MDP. The current findings suggests that correctional staff appear to refer inmates on the basis of general psychopathy whereas mental health providers appear to offer MHT on the basis of disorder type, where psychotic inmates were found to more likely to be offered MHT than those with a mood disorder who in turn were more likely to be offered MHT than those with an anxiety disorder. Clearly, the current trend found here suggests that disorder type is likely to be a factor in the treatment delivery process which concurs with the literature and tentatively supports the sixth research hypothesis.

In light of the emphasis placed on chronicity and severity under policy standards, it was hypothesised that disorder severity would be associated with the provision of treatment. Supporting this hypothesis, it was found that severity regardless of disorder type (the "comorbid disorder severity" factor) was significantly associated with the provision of MHT. In other words, it was found that participants with at least one severe disorder were more likely to be offered MHT than those with at least one disorder at the moderate level of severity. However, this relationship was not found to be linear, as more participants with at least one mild disorder were found to be offered MHT than those with at least one moderate disorder. This indicates that disorder type may be a factor in this regard. Severity in relation to disorder type (i.e., the severity rating of the most overt disorder) was not found to be a statistically significant factor. However, when the raw data is perused there appears to be a trend indicating that there is an association between severity in relation to disorder type and MHT offered. This indicates that with a larger sample a significant result may have been obtained. The finding that severity appears to be associated with the provision of MHT is consistent with the general view within the literature (Hodgins, 1995; Steadman et al, 1989; Teplin, 1990) and concurs with the emphasis placed on severity under policy.

Mental Health History. In light of the apparent reliance on recorded previous mental health problems reported in the literature, it was hypothesised that mental health history would have an impact on the provision of treatment. However, this postulation was not supported by the current findings, which is inconsistent with the

general literature. This finding may be due to the fact that the cell size was small, which means is that with a larger sample a significant relationship may have been found. However, this may not be the case as the majority of detected MDP in this study had some mental health information record on their files. This indicates that, while mental health history appears to be an important factor in the detection process it may have less bearing on the provision of treatment. What this suggests is that when these two independent systems are viewed separately the general postulation in the literature that mental health history is associated with treatment delivery may be somewhat misguided.

Personality Traits. Personality traits were postulated to influence treatment delivery and this hypothesis was supported in that two of the traits measured via the TCI were found to have a statistically significant association with treatment delivery. As in the detection process, it was found that co-operativeness was related to the provision of treatment. However, this significant relationship was the inverse of that found in the detection process. In other words, it was found that inmates who had lower co-operativeness scores were more likely to be offered treatment. What this indicates is that, unlike the detection process, disruptiveness may be a factor in the delivery of treatment. As highlighted in section 1.7., there are some inconsistencies within the literature regarding the association disruptiveness has with the provision of MHT. It has been argued by members of both systems that the other is reluctant to contain such MDO due to management issues (Adams, 1986; NZ Ministry of Health, 1987). The current finding suggests that disruptiveness or the lack of co-

operation may be taken as a sign of crisis by mental health providers, increasing the likelihood of treatment delivery. This concurs with the general view in the literature that factors related to a crisis state appear to increase the likelihood of treatment provision (NZ Ministry of Health, 1987; Steadman et al., 1989; Rice & Harris, 1993). Novelty seeking (sub-scale one) was the other personality trait found to be significantly associated with the provision of treatment in the current research. In line with the association found in the identification process, inmates with lower scores on this scale were found to be more likely to receive treatment than those with higher scores. While there is an absence of research directly investigating this relationship, this finding is congruent with the indirect evidence highlighted in section 1.7. As previously discussed, the novelty seeking scale is a measure of characteristics that are typical for the offender population. The current findings show that these typical "criminal" characteristics have a negative relationship with the delivery of treatment. In other words, detected MDP who exhibit fewer "criminal" characteristics were found to be more likely to receive treatment. This finding concurs with Hodgins and Côté's (1993) research findings and is also congruent with Roger and Webster's (1989) report that personality traits appear to be involved in the selection process of treatment delivery.

Substance Use Comorbidity. Alcohol and drug comorbidity issues were hypothesised to have a negative impact on the provision of MHT as this type of mental health problem is commonly viewed as a typical criminal trait and MHT for persons with such comorbidity issues appears to be quite sparse. Substance use comorbidity was

not found to have a significant association with MHT delivery. When the raw data is perused there appears to be a trend in the opposite direction than that hypothesised. In other words, while it was speculated that substance use comorbidity issues would have a negative influence on MHT delivery, it was found that more MDP with such problems were offered MHT than those without. This suggests that unlike the detection process, the presence of substance use comorbidity issues may actually increase the likelihood of MHT delivery. This finding does not support the research hypothesis as substance use comorbidity issues were not found to be significantly related to treatment delivery and the trend indicates that the presence of such issues may increase the chance of MHT offered, which does not concur with the literature. It must be noted that cell size was small and that over two-thirds of the detected MDP had alcohol and drug problems. Clearly a larger sample may add some clarify in this regard. What this finding suggests is that mental health providers are taking the common problem of self-medication into consideration in this process. In sum, the current findings indicate that a detected MDP most likely to be offered MHT is an inmate who has a severe overt disorder, with atypical criminal characteristics who is less co-operative and who has substance use comorbidity issues, which partially supports the research hypothesis.

4.3.3. THE TYPE OF TREATMENT PROVIDED.

As discussed in the literature review, one of the major concerns in this area is that the treatment provided in penal institutions is crisis based rather than comprehensive care. This has been indicated by the type of treatment provided, most notably the

apparent over-reliance on medication and the low provision of hospital care. Subsequently, it was hypothesised that the type of treatment provided would be crisis based. While sample size was too small to quantify this statistically, the descriptive data tentatively supports this hypothesis. Out of the detected participants offered treatment 42% received medication, which is in line with Wardlaw (1983) and Steadman et al (1989), who reported that medication was the most common type of treatment provided for inmates. Only two of these participants were provided with inpatient care, which concurs with the general findings in the literature that this type of treatment is offered infrequently (NZ Department of Justice, 1988: NZ Ministry of Health, 1987; Verdun-Jones, 1989). Where the current research deviates from the general literature in this regard, is with the inclusion of counselling as a MHT. Therefore it is somewhat difficult to compare this aspect to the broader research because the provision of this type of treatment has not been investigated in this context. Nevertheless, the majority of the participants offered counselling had a severe disorder and/or depression and only five participants were offered such treatment which suggests that the provision of counselling for the participants in question functioned as a form of crisis intervention. It must be acknowledged that counselling was also provided in conjunction with medication. However, yet again only five participants were offered this treatment, which concurs with the hypothesis that crisis intervention is the main impetus underlying the provision of such treatment. Clearly, the hypothesis was tentatively supported given the trend found via the descriptive data and with a larger sample more clarity is likely to be obtained in this regard.

It is important to highlight here that, although MDP with a severe and/or an overt disorder appeared to be more likely MDP to be offered treatment, 35.7% of the referred participants with a severe disorder were not offered treatment. Furthermore, while all referred participants with psychosis in the current study were provided with treatment, there were only three such participants all of whom had severe psychosis. Clearly then, these findings indicate that crisis intervention is the main form of treatment offered in the current study which concurs with the general concern in the literature, including NZ based information (NZ Department of Justice, 1988; NZ Ministry of Health, 1987; Rice & Harris, 1993; Steadman et al, 1989; Verdun-Jones, 1989). Therefore, in NZ in line with other western countries, crisis intervention is likely to be the most common form of MHT available for MDP, which predisposes many MDP to human rights infringements.

4.3.4. COMPARATIVE ASSESSMENT OF REHABILITATIVE MHT DELIVERY.

To recap, the secondary consideration of this research was the provision of rehabilitative MHT for prisoners. Therefore, the fourth and final aim of the third objective was to quantify the delivery system for rehabilitative MHT at Paparua Prison to compare the provision of rehabilitative MHT with the provision of MHT for MDP. Again, this analysis was limited to three common rehabilitative needs (i.e., alcohol and drug issues, sexual offence issues, and violence offence issue). Given the apparent availability of rehabilitative MHT it was hypothesised that the provision of this type of treatment would be greater than the provision of treatment for MDP. The provision of treatment was not found to be

significant for any of the three rehabilitative needs investigated. In other words, the provision of treatment was not found to be beyond the level of chance for these three groups, which does not support this hypothesis. However, given the raw numbers it is apparent that more participants referred for rehabilitative MHT were offered treatment than those referred for MHT. This shows that delivery for rehabilitative treatment is higher than humane containment based treatment and suggests that a larger sample may have yielded a significant finding. In other words, the current finding shows that the provision of rehabilitative MHT is greater than that of MHT but is insufficient to cater for the demand. As this finding is only trend setting rather than statistically significant it clearly only partially supports the hypothesis in question. What this finding indicates is that while the emphasis under policy on criminogenic needs is likely to be a major factor in the current level of treatment provision it is still not enough to cater for the present demand. While this finding does not support the hypothesis it is in line with reports on the gap between the supply and demand for such services (NZ Department of Justice, 1989; Severson, 1992; Steadman et al, 1989). Therefore while the current findings indicate that more prisoners are likely to be offered rehabilitative MHT than those offered MHT, proportionately speaking the delivery of rehabilitative MHT is no better than the delivery of MHT.

4.4. PRESENT STUDY LIMITATIONS AND FURTHER RESEARCH OPTIONS.

The participant sample was a good representation of the NZ male prison population. However, certain precautions must be noted. The fact that the participant sample was drawn from a prison in

the South Island (Christchurch Paparua Men's Prison) means that there could be a bias in this sample due to geographic factors. For example, there was a slight under-representation of Maori prisoners which may reflect the location of the research. While Maori prisoners were under-represented in this sample such persons were over-represented in the mentally disordered group. This produces considerable concern regarding the degree of vulnerability Maori mentally disordered persons have for arrest and incarceration. Clearly a replication of the current study in a North Island prison would provide a more holistic picture of the MDP access to MHT in NZ and may also provide further insight into the proportion of mentally disordered Maori prisoners in this country. The current sample was purposefully restricted to prisoners serving a long-term prison sentence. However, there is some research evidence that indicates MDO who are convicted for committing minor offences are increasingly being diverted to the penal system. It would be useful to investigate this issue in NZ as it would provide further insight into the prevalence of MDO in penal custody.

In the current study a discriminant function analysis was performed to determine if any variables could discriminate between detected and non detected MDP. This analysis yielded significant results, showing that group membership could be predicted according to the variables selected. However, it is important to note that these results are trend suggesting as opposed to robust findings. This is due to the fact that; the sample size was relatively small for this multi-variant analysis, there was a disproportionate number of variables entered, and jack-

knifing techniques were used to establish the predictive power of the discriminant function. This does not negate the validity of the findings gained from this analysis; however, a replication study with a larger sample would be beneficial to affirm the current results.

In the present study the detection and referral process in operation was not found to function at an acceptable level of efficiency for the identification of MDP. Moreover, with the exception of the referral rate for prisoners with alcohol and drug related issues, the identification of prisoners for rehabilitative MHT was also found to be inefficient. It is apparent that correctional staff are primarily responsible for the identification of MDP which is essential for the provision of MHT. The current research findings indicate that correctional staff are sensitive to certain aspects of mental disorder symptomatology, however, personality traits were found to be the most influential factor in this process. Given the importance of this process a more indepth investigation into correctional staff's view on such issues as; prisoners' rights, MDP, the provision of MHS in prison, and the validity of the referral process, may provide some essential insight into the dynamics involved in the detection process so that practical changes can be implemented.

The scarce level of treatment delivery found in the current study indicates that even if prisoners are detected as requiring MHT under humane containment requirements or under rehabilitative objectives, there is little likelihood that such persons will receive treatment. This finding supports the current speculation in this country that in accord with other western nations crisis

intervention is the main form of MHT available for MDP and that the demand for rehabilitative MHT outweighs the supply. As outlined in this discussion there are several problematic areas within the treatment delivery system in operation. However, it must be noted, that due to the nature of the current research and time restraints, an indepth analysis of the MHS was not conducted. In this country, in line with other western nations, there is an emphasis placed on the provision of MHT as a condition of parole for many inmates (Dvoskin & Steadman, 1989; Greene, 1988; NZ Department of Justice, 1988; 1989). The majority of this type of MHT offered post-release is rehabilitative and it constitutes the provision of care for rehabilitative needs rather than humane containment rights. Clearly, the perusal of this data was outside the current research framework. However, what this indicates is that more prisoners in need of rehabilitative MHT and MDP may have been offered assess to such services. Moreover, the author became aware that there was missing information in the criminal justice and medical files, which means that more MHT may have been offered than that presently collated. This is unlikely to have a large impact on the validity of the current findings, especially regarding the provision of crisis intervention. Nevertheless, a more indepth investigation of MHS that cater for prisoners may provide a more comprehensive picture of the provision of MHT and the operations of this multifaceted system.

The high rate of co-occurring clinical disorders, especially substance use comorbidity, was one compelling finding in the current research. This current finding concurs with other research findings, where it has been found that mentally disordered persons

with co-occurring disorders, most notably substance use comorbidity, appear to be more vulnerable to residing in penal custody. This is an area that needs to be perused in more depth in this country. The substantial proportion of participants found to have co-occurring disorders other than substance use, raises some important questions regarding such persons vulnerability in the community, and detection and treatment provision in prison. Clearly further research in this area may provide some valuable insight into why these persons appear to be vulnerable to penal containment and how to improve treatment provision.

In NZ, in line with other western countries, there is a lot of interest regarding the plight of MDO, relating to public safety issues and the protection of such persons' rights. The primary impetus of this interest has been the mental health twin policy of deinstitutionalisation and community care. However, there is clearly a dearth of research investigating the impact this policy and the associated legislative changes have had on this "doubly deviant" group. Furthermore, while these changes in the mental health system, in conjunction with changes in the CJS, have brought attention to the provision of MHS in prisons, empirically based investigations have been somewhat absent. Clearly, the aim of this research was to address this gap, however, further research is necessary to understand the nature of the impact these system changes have had on MDO in this country. For example, NZ research investigating the diversion options available to police and to the court for MDO, would be a valuable contribution. It would also be beneficial to establish whether or not there is a significant increase of MDO residing in penal custody post-

deinstitutionalisation. A more accurate picture is likely to be obtained in this country as opposed to the US or England because deinstitutionalisation has not been in full force for as long. The estimated prevalence rate established in the current research could function as a base rate for further investigations in this regard.

4.5. RESEARCH IMPLICATIONS AND PRACTICAL RECOMMENDATIONS.

The "Gap" between Paper and Practical Rights. The present research findings suggest that there is a serious gap between MDP's paper and practical rights to MHT, making MDP extremely vulnerable to human rights infringements. This finding supports Keilitz and Roesch's (1992) assertion and also concurs with the view expressed in NZ and overseas, that this important human right is relatively difficult to uphold, if not unenforceable in real-terms, due to the nature of the present legal framework (Cohen, 1993; NZ Department of Justice, 1988). Manifestly, this research validates the current growth of concern regarding the real commitment to international standards of conduct that have been ratified by respective nations. While several western countries, including NZ, have officially endorsed international standards of treatment for prisoners, which encompass MDP's entitlement to MHT, the current findings support the view that such standards are not adequately incorporated into national or regional law (Bayefsky, 1992; NZ Department of Justice, 1988; van Zyl Smit & Dünkel, 1991). The point made by Monahan (1982), that positive rights or entitlements are not adequately articulated in legal terms as opposed to negative rights, appears to be typified when perusing MDP's entitlements to MHT. It is apparent that in NZ, in

accord with other western nations, policy functions as the primary form of protection for prisoners' positive rights, which constitutes the weakest form of legal protection available. Even when more detailed policy standards or codes of treatment are generated from generic policy objectives, difficulties in implementing such standards still commonly arise. As found in the US, while court action in this country may serve to affirm this constitutional right to treatment, this avenue is unlikely to remedy the present ambiguity found within the legal framework that depicts MDP' rights to MHT. Therefore, in accord with the recommendations made by the NZ Department of Justice (1988) in the inquiry into this countries prison system, amendments to the pertinent legislation appear to be the best avenue available to narrow this *gap* between MDP' paper and practical right to MHT.

While amendments in legislation appear to be imperative for any real improvement in the legal protection provided, policy clearly plays a major role in the fulfilment of positive rights. It is apparent that policy reform is also required. The fuzzy boundaries depicting the dual purpose of providing MHS for prisoners, commonly found across countries and jurisdictions, appears to be a major obstacle in the fulfilment of this right. Manifestly, more clarity is required under legislation and policy, regarding the purpose of providing MHS and prisoners' eligibility to MHT. In the current study the author has provided a tentative framework, based on the available literature, which specifies typical mental disorders that fall within the bounds of MDP' entitlement to MHT under humane containment. It is recommended that this typology

is utilised as a point of reference for legislative changes and policy reform in this area.

Estimated Base Rate of MDP. As discussed above, an important aim of this research was to provide a more tangible framework so that the issue of the humane containment of MDP and the protection of such persons' rights could be more easily addressed. Establishing an estimated base rate of MDP who suffer from a clinical mental disorder deemed to fall within the legal framework of prisoners' constitutional right to MHT was viewed by the author as an essential starting point for this important human rights issue to be properly addressed at the practical level. Clearly, the estimated base rate established in the current research has an important role for further developments in the provision of humane containment for MDP in NZ and overseas. The current research findings indicate that there is a significant proportion of prisoners who suffer from a clinical disorder that entitles such persons to access to MHT. This affirms the importance of the provision of MHS for the prison population. Moreover, the high rate of co-occurring disorders and substance use comorbidity found within the research sample supports the policy objective that a comprehensive MHS system is required for the penal population. Clearly, these research findings validate policy aims and survey based research and also affirm that a comprehensive MHS system is *essential* for the protection of MDP human rights, given the diverse and complex nature of this group.

The Identification Process. These present findings provide some scientific support for the contemporary concern regarding this process within the penal system and also adds further insight into

certain assertions made within the literature. The current research finding, that the identification of MDP is considerably low within in the prison system, shows that this service system is in serious need of further development for the protection of MDP' constitutional right to MHT. As evidenced in the literature review, the screening schedules most commonly utilised are generic crisis based assessments and criminogenic oriented schedules. This is likely to be a primary factor in the low detection rate in the current research as these forms of screening are insensitive to the majority of disorder symptomatology and are not clinically based. The present findings clearly support the view of Hodgins (1995) and Ogloff et al (1993) that clinically driven mental health assessments should be used for the identification of MDP and the employment of such schedules is recommended.

The time of screening is also likely to be a factor involved in the findings of the current research. In the present research screening at admission was found to be the most common time that a mental health assessment was undertaken, which is consistent with reports for overseas (Ogloff et al, 1993, Steadman et al, 1989). As discussed in the literature review, while screening at intake is imperative it cannot be over-emphasised that, for the protection of MDP' rights, it is essential that additional assessments are undertaken throughout inmates' prison-term. The current research highlights the need for this given that the majority of the participants were screened by the author mid-way through their prison terms. It is a policy requirement in NZ to screen long-term prisoners periodically throughout their sentence, however, the author found that this was undertaken in an ad hoc fashion.

Moreover, the screening in question primarily relates to security issues and criminogenic concerns. Clearly then, it is recommended that mental health screening is required periodically, alongside criminogenic and security evaluations and that this should be mandatory rather than a policy aim.

As evidenced in the literature review, one of the primary issues of concern regarding the identification of MDP is the high involvement correctional staff have in this process. While the detection and referral rate was not found to be adequate, the current findings still suggest that correctional staff have some discernment regarding psychopathology, which is consistent with research by Toch and Adams (1988) and also concurs with research investigating police detection rates (Holley & Arboleda-Florez, 1988; Teplin & Pruett, 1992). This supports the view that, with adequate training and efficient procedures in operation, correctional staff are likely to attain a sufficient rate of detection. Clearly then, it is recommended that the training provided for correctional staff is reviewed and amended accordingly.

It is clear that any new developments that take place within the identification process are dependent on resource availability. In other words, cost efficiency is an essential consideration. As discussed in the literature review, the deployment of clinically based screening schedules can be costly due to the employment of mental health professionals. Clearly, the provision of periodic mental health assessments for prisoners throughout their sentence, as proposed above, could become a costly procedure to implement. At present, the way the cost of detection appears to be

addressed is via the deployment of correctional staff and, more pertinently, the use of "crisis intervention screenings" often in the form of generic and informal screening procedures. This avenue is commonly used to "flag" those in "serious need" for a more an indepth mental health evaluation. Given the current findings in conjunction with the broader literature, it is apparent that this ad hoc procedure needs to be reviewed. A tentative procedure can be drawn from the current study as a cost-efficient option. The TCI, which is simply a self-report questionnaire that can be administered if required, proved to be a useful tool in this study. This inventory could easily function as a primary schedule in the screening process. As previously mentioned, while not a diagnostic schedule, this inventory was "designed" to discern individuals who are vulnerable to mental health problems. By administering this inventory at the initial and subsequent screening points, such vulnerable individuals could be "flagged" for further and more extensive evaluations. The advantage of this form of "flagging" over that provided by crisis based screening, is that this inventory is clinically based and more sensitive to general disorder symptomatology. Therefore it is recommended that the viability of incorporating an inventory, such as the TCI, is investigated as this is likely to improve the efficiency of the identification process without greatly increasing the cost.

It is clear that in NZ and other western countries, there are some positive policy standards and guidelines aimed at providing a functional identification system for MDP and for prisoners' generic needs, most notably, rehabilitative issues. What the current research affirms, however, is that even very sound policy

objectives can be lost in the day-to-day running of a social system. This is exemplified by the comparatively low detection and referral rate found for inmates with rehabilitative needs in the current study, as the rehabilitative or reintegrative objectives are commonly more clearly articulated under penal policy than the associated guidelines than humane containment requirements. What appears to be the fundamental problem is the absence of a comprehensive legal framework defining the requirements of an identification system. As evidenced in the literature review, across most western countries, the detection and referral process is barely addressed within the pertinent legislation which allows for the ad hoc system that appears to be prevalent across countries. The significance of the detection and referral process in the protection of MDP' rights can not be overstated, given that this process is rudimentary to prisoners' access to MHS. Subsequently, it is recommended that the necessary amendments are made within the legislation so that an identification system is mandatory.

The Treatment Delivery System. The current findings generated from the investigation into the MHS system also provide some essential scientific credence to the current concern regarding the provision of MHT for MDP. The current findings in this regard collectively indicate that *crisis intervention* is the most common form of treatment provided for MDP, which supports the general view held in the literature. Clearly, this service system requires further development to protect MDP adequately from human rights infringement. While the provision of crisis intervention complies with the minimum standards required, it does not equate to the

provision of services necessary for the protection of MDP' constitutional right to MHT. In line with the general literature, the current findings indicate that a significant proportion of MDP are likely to reside in prison without receiving treatment even when such individuals have been appropriately detected. While the legislative requirements in this regard are more pronounced than those found for the identification process, it is apparent that amendments are essential to bridge the gap between the minimum standards of treatment and the policy objective of a comprehensive MHS system.

Clearly, policy standards for the provision of MHT influence MDP' access to such services. As discussed in section 1.7., the emphasis on minimum standards in the legislation and the problem of resource scarcity, seems to have produced a narrow focus under policy on the provision of MHS for the chronically mentally ill in prison (Cohen 1993; Dvoskin and Steadman, 1989). This appears to be the case across countries and jurisdiction and the NZ situation is no exception. The emphasis placed on the provision of MHS for severely MDP under the NZ Penal Institutions Policy and Procedures (1995) is likely to be a factor in the low level of treatment delivery found in this study. There is clearly a relationship between this directive under penal policy and the type of MHS solicited for the provision of treatment for this population. When this is taken into consideration, in conjunction with the fact that prisoners are commonly just one of many groups that most service providers are responsible for, it is not surprising that the provision of MHT in the form of crisis intervention appears to have become the norm. However, the underlying rationale of this policy

directive is not to deny MDP' their constitutional right to MHT but to prioritise the provision of scarce resources. Clearly, the emphasis placed on chronicity and/or severity under policy needs to be reviewed as this appears to skew the focus away from the fundamental policy objective of providing a comprehensive MHS system for the protection of MDP' constitutional right to MHT.

As indicated above the prioritisation system in operation appears to be another factor that limits the provision of MHT to crisis intervention. While all service providers have varying treatment criteria, it is apparent that chronicity and/or severity is the most common emphasis under penal policy. The current research findings indicate that in NZ, as found elsewhere, severity and disorder type are important factors in the provision of treatment. However, it can not be overstated that within the context of humane containment requirements certain MDP have the constitutional right to access to MHT regardless of the severity and disorder type. While this does not negate the importance of the prioritisation of resources or the provision of treatment for chronically ill individuals, it indicates that crisis intervention for such persons does not constitute the requirements that are essential for the protection of MDP' rights. Again, it is important to acknowledge that while these factors appear to improve the chance of being offered treatment, severely disordered persons can still reside in prison without the offer of treatment. It is apparent that with crisis intervention as the primary form of treatment offered the prioritisation process needs to be reviewed. The suggested prioritisation criteria discussed in section 1.7, may be a more amenable method for treatment provision. Roger and

Webster (1989) propose that treatability would be a more appropriate criteria for the prioritisation process. In accord with this approach MDP suffering from severe anxiety disorders, for example, would have a better chance of rightfully receiving MHT, given the relatively high treatment success rate for such disorders. The endorsement of this approach also has its merits in regard to the types of treatment methods employed for this population. In the current study, two of the participants provided with MHT, in the form of medication and counselling, met the commitment criteria for hospitalisation. Moreover, the counselling provided for several of the treated participants was of an informal nature by prison medical staff. Without dismissing the importance of this form of crisis intervention, this type of treatment is only likely to ameliorate the crisis state rather than the disorder per se. Given the typology presented in the current research, the primary disorders in question are psychosis, mood disorders, and anxiety disorders. Manifestly, the provision of corresponding treatment techniques are required in the MHS system for prisoners. While there is some debate regarding the efficacy of certain treatment methods, especially for mood disorders, this is outside the scope of this discussion. The point at hand, as outlined in section 1.7, is that treatment success is commonly used as the criteria for treatment delivery and that this is generally measured via recidivism rates for this population. While this is valid for the provision of rehabilitative MHT, the criteria of treatability is more appropriate for the provision of humane based MHT. Therefore, it is recommended that the prioritisation process is reviewed, focusing on the issue of humane containment and treatability rather than rehabilitative objectives.

The results of the current study highlight the need for efficient system and service co-ordination for the provision of adequate and appropriate treatment. While several variables are likely to come into play, a lack of system co-ordination may well be a factor in the gap found in the present study between those who were appropriately offered treatment and those who were appropriately referred for MHT and rehabilitative MHT. As highlighted in the literature review, some form of co-ordination strategy is commonly found to be in operation between these two systems. However, in line with the literature, the author found that the efficiency of this co-ordination rested heavily on certain devoted individuals rather than the formal strategies in place. While there are several factors that influence system co-ordination efficiency such as, role conflict, time restraints and resource limitation, the pivotal obstacle appears to be a lack of goal clarity. As discussed in section 1.7., this appears to magnify system conflict and professional scepticism which can hinder the efficiency of a social system. As Reali and Shapland (1986) found, ongoing communication and education appear to be effective means to reduce system tensions and increase service efficiency. The "boundary spanner" concept, which has been found to be an asset for system co-ordination at the pre-sentencing level in the CJS, could easily be incorporated at the penal level. Therefore, it is recommended that the communication channels between correctional staff and mental health providers are reviewed to provide further insight into how co-ordination could be improved.

As highlighted in the literature review, service co-ordination appears to be another problematic area in the provision of services

for MDP, primarily because both community and penal based service providers commonly have several client groups that they cater for and prisoners appear to be low on the priority list. This factor may well be related to the low rate of treatment delivery for MDP and of rehabilitative MHT found in the current study. Clarity also appears to be the pivotal problem in this area, mainly relating to the purpose of treatment provision and the target groups. The ambiguity regarding the dual purpose of providing MHT overflows into this aspect of treatment provision, which clouds what type of MHS are required for this population. In conjunction with the utilisation of multiple service providers, this appears to have produced a lack of clarity regarding who is responsible for whom. In other words, service providers can gain a false sense of assurance that treatment and/or certain target groups that they do not cater for will be eligible for treatment provided by other agencies. Furthermore, with the trend of service specialisation, certain individuals are denied access to treatment due to the stringent treatment criteria specified by the given service provider. Even service providers that solely cater for prisoners, have to have stringent criteria due to treatment objectives and the high demand for services. As discussed in section 1.8., the problem is that service specialisation, especially in the community based agencies, has largely limited access to treatment for mentally disordered persons with multiple mental health issues. As evidenced in the present research and found overseas (Hodgins, 1995; Peters & Hills, 1993), there appears to be a disproportionate number of MDP with co-occurring disorders, especially substance use comorbidity. In line with Severson (1992), this finding emphasises the need for a comprehensive MHS system that takes a

more holistic approach to treatment provision. The "boundary spanner" concept, could also easily be adapted to enhance the co-ordination between service providers as well as systems. Therefore it is recommended that, with a holistic approach to MHT and the "boundary spanner" concept in mind, there is a review of what services are involved in treatment delivery and how co-ordination could be improved.

What is apparent is that the aforementioned problems involved in the provision of treatment largely relate in some form to the level of resources available. While the raw data revealed that the provision of rehabilitative MHT was more prevalent than the provision of humane based treatment, the level provided was found to be far from adequate. The low delivery rate of treatment found in this study clearly shows that the provision of a comprehensive MHS system is far from achieved in this country. The fact that the nature of a disorder and the presence of co-occurring disorders were not found to have a significant impact on the delivery of treatment raises some concern regarding the prioritisation system in operation. These findings suggest that the MHS system is itself in crisis. Resource limitation is likely to be the major factor in this regard. In the current study, for example, the Regional Forensic Services was the major community based provider of treatment, which primarily constituted the provision of care for two participants. This finding concurs with the general findings across countries that community based care, especially hospital treatment, is difficult to obtain for the prison population. This lack of availability is most likely related to the implementation of the twin policy of deinstitutionalisation and community care,

which highlights that a penal based system is essential for the provision of MHT for inmates. However, what has also been indicated in the current study is that prison based services are also a scarce resource. Clearly, what is fundamental for the provision of a comprehensive MHS system is an increase of resources. While this may be somewhat of a challenge, it is recommended that more resources are accrued from government funding and are allotted for prisoners by the respective mental health agencies.

4.6. FINAL COMMENTS AND CONCLUSION.

It has been established via this multifaceted investigation that there is a substantial gap between MDP paper and practical rights. The current findings indicate that there is a significant proportion of MDP who are likely to have co-occurring disorders and substance use disorder comorbidity, which supports the assertion that a comprehensive MHS system is required for this population. The analysis of the detection and referral process revealed that "atypical" criminal characteristics and the presence of more visible psychopathology increased the likelihood of detection. However, it was also found that there was a relatively low chance of being appropriately detected and referred. These findings support the view that there are a reasonable number of MDO residing in prison who are unlikely to be appropriately detected. The current investigation of the treatment delivery system evidenced that crisis intervention is the main form of treatment offered and that severity, disruptiveness and "atypical" criminal characteristics had the most influence on the provision of treatment. This substantiates the assertion that MDP have a low

chance of receiving MHT while in prison and supports the view that such positive rights are relatively unenforceable at present. The comparatively low referral rate and low rate of treatment delivery found for rehabilitative MHT in the current study indicates that prisoners' general access to MHT is relatively insufficient.

The current social pressure for better public safety measure in NZ, which is in accord with other western countries, is not likely to diminish in the immediate future. The more recent changes in the CJS do not appear to have effectively addressed the issue of the growing crime rate, most notably that of violent crime. Additionally, while there has been some opposition throughout the process of deinstitutionalising the mental health system, it is apparent that this twin policy is now firmly incorporated into the NZ mental health system and that the social management of mentally disordered persons in this country is beginning to emulate that found overseas. This social climate indicates is that prisons are likely to continue to be overcrowded, in spite of the least restrictive objective, which means that vulnerable individuals are more likely to experience deterioration in prison given this environmental stress. It also indicates that more mentally disordered persons are more likely to come into contact with the CJS and that MDO are less likely to be diverted away from the penal system and are more likely to reside in penal custody.

The present research findings indicate that the current systems in operation are not able adequately to protect MDP' basic human right to MHT. The fact that more MDO are likely to reside in prison due to "environmental decompensation" and reduced diversion options, makes it apparent that this matter urgently needs to be

addressed. Several recommendations have been presented in this study based on the current research findings to aid the implementation of some practical solutions in this area. It is apparent that the primary obstacles in bridging the gap between MDP' paper and practical rights are the ambiguity of the legal framework and resource availability. It is also clear that the rights of this group of offenders has received relatively little attention over the last few decades. In accord with Slovenko (1989) it is important to let common sense be the guide for legislative changes, however, it is not until prisoners' rights are clarified within the legislation that appropriate levels of funding can be justifiably allotted for MDP' access to MHS. While prisoners' rights is a controversial issue, the point in question is about fulfilling the rights that are afforded. This research has affirmed that there is a substantial proportion of MDP who are morally and legally entitled to MHT in this country. The blurring of the dual purpose for providing MHT for prisoners appears to be a significant obstacle in the provision of essential MHT for the protection of MDP' human rights. The rehabilitative objective for the provision of MHS appears to overshadow MDP' constitutional right to MHT under humane containment principles. This is the primary area that needs to be addressed for legislative and policy reform. The typology presented here could be utilised as a framework for legislative amendments and policy changes for the protection of MDP' entitlement to MHT. While expenditure on prisoners is a controversial issue, as a society we must consider the human and social cost of not fulfilling MDP' right to be humanely contained.

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APPENDIX (a)

University of Canterbury Department of Psychology

Consent Form

The reason for this project is to find out who is in need of mental health care within Prison, and who are receiving it.

Your tasks within the project would be to be interviewed during which you would be asked questions about yourself, such as your mood and some life experiences you have had. Secondly we would like you to complete a questionnaire about your general opinions and feelings. The interview is likely to take about an hour, and the questionnaire may take 30-40 minutes to complete.

Your answers to the questions both in the interview and to the questionnaire will remain confidential, unless you tell us you want to harm yourself or somebody else. We are ethically obliged under those circumstances to refer you to the Prison Medical Services in order for you to get the help you would need. The results of the project will be published but your identity will not be revealed in any way.

Your participation in this project is absolutely voluntary. You will get no direct advantage from participating in terms of privileges or conditions, but participating will not count against you in any way. You may stop participating at any point and request the return of any information you had provided up until that point.

I agree to participate in the project described above, on the understanding of these conditions.

Name: .....

Signature: ..... Date: .....

APPENDIX (b)

STRUCTURED CLINICAL INTERVIEW FOR DSM-III-R—PATIENT EDITION (WITH PSYCHOTIC SCREEN)

SCID-P (W/PSYCHOTIC SCREEN) (Version 1.0)

Robert L. Spitzer, M.D.; Janet B. W. Williams, D.S.W.;
Miriam Gibbon, M.S.W.; and Michael B. First, M.D.

01
1-2

Study: _____ Study No.: — — — — 03-06

Subject: _____ I.D. No.: — — — — 07-10

Rater: _____ Rater No.: — — — 11-13

Rater is: Interviewer 1 14
Observer 2

Time interview began _____ Date of interview: — — — — — — 15-20
ended _____ Mo. Day Year

Evaluation: Initial 1 21
Reevaluation 2

Sources of information (check all that apply): 22
__ Subject
__ Family/friends/associates 23
__ Health professional/chart/referral note 24

___ Consultation with: _____ 25

Form No. 03
79-80*

Edited and checked by: _____ Date: _____

*Keypunch: Duplicate on all cards; "b" = leave blank.

The development of the SCID has been supported in part by NIMH Contract #278-83-0007(DB) and NIMH Grant #1 R01 MH40511.

For citation: Spitzer Robert L., Williams Janet B. W., Gibbon Miriam, and First Michael B.: "Structured Clinical Interview for DSM-III-R—Patient Edition (With Psychotic Screen)—SCID-P (W/PSYCHOTIC SCREEN)—Version 1.0," Washington, DC, American Psychiatric Press Inc., 1990.

SCID-P (W/PSY SCREEN) SUMMARY SCORE SHEET

Duration of interview (minutes): ___ ___ ___

DIAGNOSIS	LIFETIME PREVALENCE				MEETS SYMPTOMATIC DIAGNOSTIC CRITERIA PAST MONTH	
	INADEQUATE INFO.	ABSENT	SUB-THRESHOLD	THRESHOLD	ABSENT	PRESENT
MOOD DISORDERS						
01 Bipolar Disorder (D.1)	?	1	2	[3] →	1	3

- [1] manic
- 2 depressed
- 3 mixed

- [1] mild
- 2 moderate
- 3 severe, without psychotic features
- 4 with mood-congruent psychotic features
- 5 with mood-incongruent psychotic features

02 Other Bipolar Disorder	?	1	2	[3] →	1	3

26b
27.
29
30
31
32
33
34
35

DIAGNOSIS	LIFETIME PREVALENCE				MEETS SYMPTOMATIC DIAGNOSTIC CRITERIA PAST MONTH		
	INADEQUATE INFO.	ABSENT	SUB-THRESHOLD	THRESHOLD		ABSENT	PRESENT
MOOD DISORDERS							
03 Major Depression (D.2)	?	1	2	[3]	→	1	3

36 37

1 mild
2 moderate
3 severe, without psychotic features
4 with mood-congruent psychotic features
5 with mood-incongruent psychotic features

38

04 Dysthymia (current only) (A.16)	?	1	2	3			

39

1 primary
2 secondary

40

05 Depressive Syndrome Superimposed on Chronic Psychotic Dis. (D.2)	?	1		[3]	→	1	3

41 42

DIAGNOSIS		LIFETIME PREVALENCE				MEETS SYMPTOMATIC DIAGNOSTIC CRITERIA PAST MONTH		
		INADEQUATE INFO.	ABSENT	ABUSE	DEPENDENCE	ABSENT	PRESENT	
	PSYCHOACTIVE SUBSTANCE USE DISORDERS							
12	Alcohol (E.4)	?	1	2	3 →	1	3	43 44
13	Sedative-Hypnotic-Anxiolytic (E.13)	?	1	2	3 →	1	3	45 46
14	Cannabis (E.13)	?	1	2	3 →	1	3	47 48
15	Stimulant (E.13)	?	1	2	3 →	1	3	49 50
16	Opioid (E.13)	?	1	2	3 →	1	3	51 52
17	Cocaine (E.13)	?	1	2	3 →	1	3	53 54
18	Hall./PCP (E.13)	?	1	2	3 →	1	3	55 56
19	Poly Drug (E.13)	?	1		[3] →	1	3	57 58
20	Other (E.13)	?	1	2	3 →	1	3	59 60

75-78 b
03
79-80
Duplicate on all cards

DIAGNOSIS		LIFETIME PREVALENCE				MEETS SYMPTOMATIC DIAGNOSTIC CRITERIA PAST MONTH		
		INADEQUATE INFO.	ABSENT	SUB-THRESHOLD	THRESHOLD	ABSENT	PRESENT	
								02 duplicate 15 (1-2, 3-14)
	ANXIETY DISORDERS							
21	Panic Disorder (F.2)	?	1	2	[3] →	1	3	16 17
	[1] without Agoraphobia [2] with Agoraphobia							18
22	Agoraphobia without History of Panic Disorder (AWOPD) (F.6)	?	1	2	[3] →	1	3	19 20
23	Social Phobia (F.9)	?	1	2	[3] →	1	3	21 22
24	Simple Phobia (F.11)	?	1	2	[3] →	1	3	23 24
25	Obsessive Compulsive (F.13)	?	1	2	[3] →	1	3	25 26
26	Generalized Anxiety (current only) (F.17)	?	1	2	3			27

DIAGNOSTIC CERTAINTY FOR CURRENT DIAGNOSES

CODE CERTAINTY OF THE *PRESENCE* OF AT LEAST ONE DISORDER IN A DIAGNOSTIC CLASS, OR THE *ABSENCE* OF ANY DISORDER IN THAT DIAGNOSTIC CLASS

	Poor	Fair	Good	
MOOD DISORDERS	1	2	3	41
PSYCHOTIC DISORDERS	1	2	3	42
PSYCHOACTIVE SUBSTANCE USE DISORDERS	1	2	3	43
ANXIETY DISORDERS	1	2	3	44
SOMATOFORM DISORDERS	1	2	3	45
EATING DISORDERS	1	2	3	46
ADJUSTMENT DISORDER	1	2	3	47

INTERVIEWER'S DIAGNOSES, IF DIFFERENT FROM SCID DIAGNOSES:

_____ _____ _____

DSM-III-R AXIS V: GLOBAL ASSESSMENT OF FUNCTIONING SCALE

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Indicate appropriate code for the LOWEST level of functioning during the week of POOREST functioning in past month. (Use intermediate level when appropriate, e.g., 45, 68, 72.)

48
Code ___ 49

90 | 81 **Absent or minimal symptoms** (e.g., mild anxiety before an exam), **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g., an occasional argument with family members).

80 | 71 **If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (e.g., difficulty concentrating after family argument), **no more than slight impairment in social, occupational, or school functioning** (e.g., temporarily falling behind in school work).

70 | 61 **Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy, or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal relationships.**

60 | 51 **Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (e.g., few friends, conflicts with co-workers).

50 | 41 **Serious symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job).

40 | 31 **Some impairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

30 | 21 **Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends).

20 | 11 **Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of death, frequently violent, manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (e.g., smears feces) **OR gross impairment in communication** (e.g., largely incoherent or mute).

10 | 1 **Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicide act with clear expectation of death.**

0 **Inadequate Information**

INTRODUCTION TO OVERVIEW

I'm going to be asking you about problems or difficulties you may have had, and I'll be making some notes as we go along. Do you have any questions before we begin?

DEMOGRAPHIC DATA

SEX: 1 male 2 female 50

ETHNICITY: 1 Black, not of Hispanic origin; 2 Hispanic; 3 White, not of Hispanic origin; 4 American Indian or Alaskan native; 5 Asian or Pacific Islander 51

How old are you? AGE: ____ ____ 52-53

Are you married? MARITAL STATUS (most recent): 1 never married; 2 married once; 3 divorced; 4 divorced, remarried; 5 widowed; 6 widowed, remarried 54

IF NO: Were you ever?

Any children?

IF YES: How many? _____

Where do you live? _____

Whom do you live with? _____

EDUCATION AND WORK HISTORY

How far did you get in school? EDUCATION: 1 grade 6 or less; 2 grade 7 to 12 (without graduating high school); 3 graduated high school or high school equivalent; 4 part college; 5 graduated 2-year college; 6 graduated 4-year college; 7 part graduate/ professional school; 8 completed graduate/ professional school 55

IF FAILED TO COMPLETE A PROGRAM: Why didn't you finish? _____

_____

What kind of work do you do? (Do you work outside of your home?) _____

_____

Are you working now?

→ IF YES: How long have you worked there?

IF LESS THAN 6 MONTHS: Why did you leave your last job?

Have you always done that kind of work?

→ IF NO: Why is that?
What kind of work have you done?

How are you supporting yourself now?

IF UNKNOWN: Has there ever been a period of time when you were unable to work or go to school?

IF YES: When? Why was that?

OVERVIEW OF PRESENT ILLNESS

DATE ADMITTED TO INPATIENT OR OUTPATIENT FACILITY FOR PRESENT ILLNESS

Number of weeks since admission to facility
1 < 1 week
2 1–4 weeks
3 > 4 weeks

56

When did you come to the (hospital, clinic)?

CHIEF COMPLAINT AND DESCRIPTION OF PRESENTING PROBLEM

What led to your coming here (this time)? (What's the major problem you've been having trouble with?)

IF DOES NOT GIVE DETAILS OF PRESENTING PROBLEM: Tell me more about that. (What do you mean by . . . ?)

ONSET OF PRESENT ILLNESS OR EXACERBATION

When did this begin? (When did you first notice that something was wrong?)

When were you last feeling OK (your usual self)?

NEW SXS OR RECURRENCE

Is this something new or a return of something you had before?

(What made you come for help now?)

ENVIRONMENTAL CONTEXT AND POSSIBLE PRECIPITANTS OF PRESENT ILLNESS OR EXACERBATION
(USE THIS INFORMATION FOR CODING AXIS IV.)

What was going on in your life when this began?

Did anything happen or change just before all this started? (Do you think this had anything to do with your [PRESENT ILLNESS]?)

COURSE OF PRESENT ILLNESS OR EXACERBATION

After it started, what happened next? (Did other things start to bother you?)

Since this began, when have you felt the worst?

IF MORE THAN A YEAR AGO: In the last year, when have you felt the worst?

TREATMENT HISTORY

When was the first time you saw someone for emotional or psychiatric problems? (What was that for? What treatment(s) did you get? What medications?)

(THE LIFE CHART ON PAGE v OF OVERVIEW MAY BE USED TO SUMMARIZE A COMPLICATED HISTORY OF PSYCHOPATHOLOGY AND TREATMENT)

Have you ever been a patient in a psychiatric hospital?

IF YES: What was that for? (How many times?)

Number of previous hospitalizations (Do not include transfers) 0 1 2 3 4 5 (or more)

IF GIVES AN INADEQUATE ANSWER, CHALLENGE GENTLY: e.g., Wasn't there something else? People don't usually go to psychiatric hospitals just because they are tired or nervous.

OTHER CURRENT PROBLEMS

Have you had any other problems in the last month?

What's your mood been like?

How has your physical health been? Do you take any medications or vitamins (other than those you've already told me about)? (Have you had any medical problems?) USE INFORMATION TO CODE AXIS III.

How much have you been drinking (alcohol) (in the past month)?

Have you been taking any drugs (in the past month)? (What about marijuana, cocaine, other street drugs?)

CURRENT SOCIAL FUNCTIONING

How have you been spending your free time?

Whom do you spend time with?

MOST LIKELY CURRENT DIAGNOSES:

DIAGNOSES THAT NEED TO BE RULED OUT:

LIFE CHART

Age (or date)	Life history event	Symptoms or condition	Treatment

RETURN TO OVERVIEW PAGE iv, **OTHER CURRENT PROBLEMS**

A. MOOD SYNDROMES

IN THIS SECTION, MAJOR DEPRESSIVE, MANIC, HYPOMANIC SYNDROMES, AND DYSTHYMIA ARE EVALUATED. THE DIAGNOSES ARE MADE IN **D. MOOD DISORDERS** (EXCEPT FOR DYSTHYMIA, WHICH IS DIAGNOSED IN THIS MODULE).

CURRENT MAJOR DEPRESSIVE SYNDROME	MDS CRITERIA	03 duplicate 0 (1-2 3-14 15)
Now I am going to ask you some more questions about your mood.	A. At least 5 of the following symptoms have each been present during the same two-week period (and represent a change from previous functioning); at least one of the symptoms was either (1) depressed mood, or (2) loss of interest or pleasure.	
In the last month . . . . . . has there been a period of time when you were feeling depressed or down most of the day nearly every day? (What was that like?) IF YES: How long did it last? (As long as two weeks?)	(1) depressed mood most of the day, nearly every day, as indicated either by subjective account or observation by others	? 1 2 3 16
. . . what about being a lot less interested in most things or unable to enjoy the things you used to enjoy? (What was that like?) IF YES: Was it nearly every day? How long did it last? (As long as two weeks?)	(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation by others of apathy most of the time) NOTE: DO NOT INCLUDE SXS THAT ARE CLEARLY DUE TO A PHYSICAL CONDITION, MOOD-INCONGRUENT DELUSIONS OR HALLUCINATIONS, INCOHERENCE OR MARKED LOOSENING OF ASSOCIATIONS, OR THAT ARE CLEARLY PART OF THE RESIDUAL OR PRODROMAL PHASES OF SCHIZOPHRENIA.	? 1 2 3 17 If neither item (1) nor item (2) is coded "3," go to "Past Major Depressive Syndrome," A 4
During this time. . . . . . did you lose or gain any weight? (How much?) (Were you trying to lose weight?) IF NO: How was your appetite? (What about compared to your usual appetite?) (Did you have to force yourself to eat?) (Eat [less/more] than usual?) (Was that nearly every day?)	(3) significant weight loss or weight gain when not dieting (e.g., more than 5% of body weight in a month) or decrease or increase in appetite nearly every day	? 1 2 3 18

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

During this time. . .

. . how were you sleeping? (Trouble falling asleep, waking frequently, trouble staying asleep, waking too early, OR sleeping too much? How many hours a night compared to usual? Was that nearly every night?)	(4) insomnia or hypersomnia nearly every day	?	1	2	3	19
. . were you so fidgety or restless that you were unable to sit still? (Was it so bad that other people noticed it? Was that nearly every day?) IF NO: What about the opposite—talking or moving more slowly than is normal for you? (Was it so bad that other people noticed it? Was that nearly every day?)	(5) psychomotor agitation or retardation nearly every day (observable by others and not merely subjective feelings of restlessness or being slowed down) NOTE: CONSIDER BEHAVIOR DURING THE INTERVIEW	?	1	2	3	20
. . what was your energy like? (Tired all the time? Nearly every day?)	(6) fatigue or loss of energy nearly every day	?	1	2	3	21
. . how did you feel about yourself? (Worthless?) (Nearly every day?) IF NO: What about feeling guilty about things you had done or not done? (Nearly every day?)	(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick) NOTE: CODE "1" OR "2" IF ONLY LOW SELF-ESTEEM	?	1	2	3	22
. . did you have trouble thinking or concentrating? (What kinds of things did it interfere with?) (Nearly every day?) IF NO: Was it hard to make decisions about everyday things? (Nearly every day?)	(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)	?	1	2	3	23
. . were things so bad that you were thinking a lot about death or that you would be better off dead? What about thinking of hurting yourself? IF YES: Did you do anything to hurt yourself?	(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide NOTE: CODE "1" IF ONLY SELF-MUTILATION W/O SUICIDAL INTENT	?	1	2	3	24
	AT LEAST FIVE OF THE ABOVE SXS [A (1-9)] ARE CODED "3" AND AT LEAST ONE OF THESE IS ITEM (1) OR (2)		1		3	25

Go to "Past Major Depressive Syndrome," A.4

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

ETIOLOGIC ROLE OF AN ORGANIC FACTOR IN FULL DEPRESSIVE SYNDROME

Just before this began, were you physically ill? (What did the doctor say?)

Were you taking any street drugs or medicines? (Any change in the amount you were taking?)

IF YES TO ANY OF THESE QUESTIONS, DETERMINE IF THE DEPRESSIVE EPISODE WAS INITIATED AND MAINTAINED BY AN ORGANIC FACTOR.

B.(1) It cannot be established that an organic factor initiated and maintained the disturbance.

IF ORGANIC FACTOR, DESCRIBE:

Established organic factors include: hypothyroidism, hyper- and hypoadrenocorticolism, substances such as reserpine, methyldopa, PCP, and other hallucinogens.

? 1 3 — 26

R/O Organic Mood Syndrome

Go to **"Past Major Depressive Syndrome,"** A 4

No organic etiology

Continue

(Did this begin soon after someone close to you died?)

B.(2) The disturbance is not a normal reaction to the death of a loved one (Uncomplicated Bereavement). (NOTE: Morbid preoccupation with worthlessness, suicidal ideation, marked functional impairment or psychomotor retardation, or prolonged duration suggest bereavement complicated by Major Depression.)

? 1 3 — 27

R/O Uncomplicated Bereavement

Go to **"Past Major Depressive Syndrome,"** A 4

Current episode not due to Uncomplicated Bereavement

MAJOR DEPRESSIVE SYNDROME CRITERIA A AND B ARE CODED "3"

1 3 — 28

Go to **"Past Major Depressive Syndrome,"** A 4

Current Major Depressive Syndrome

How many separate times have you been (depressed/OWN EQUIVALENT) nearly every day for at least two weeks and had several of the symptoms that you described, like (SXS OF CURRENT EPISODE)?

Total number of episodes of major depressive syndrome, including current (CODE 99 IF TOO NUMEROUS OR INDISTINCT TO COUNT)

— — 29-30

How old were you when you first had a lot of these symptoms for at least two weeks?

Age at onset of first unequivocal major depressive syndrome (CODE 99 IF UNKNOWN)

— — 31-32

Go to **"Current Manic Syndrome,"** A 8

Past Major Depressive Syndrome

IF NOT CURRENTLY DEPRESSED: Have you *ever* had a period when you were feeling depressed or down most of the day nearly every day? (What was that like?)

IF CURRENTLY DEPRESSED BUT FAILED TO MEET FULL CRITERIA, SCREEN FOR PAST MDS: Has there ever been *another* time when you were depressed or down most of the day nearly every day? (What was that like?)

IF YES: When was that? How long did it last? (As long as two weeks?)

IF PAST DEPRESSED MOOD: During that time, were you a lot less interested in most things or unable to enjoy the things you used to enjoy? (What was that like?)

IF NO PAST DEPRESSED MOOD: What about a time when you were a lot less interested in most things or unable to enjoy the things you used to enjoy? (What was that like?)

IF YES: When was that? Was it nearly every day? How long did it last? (As long as two weeks?)

Have you had more than one time like that? (Which time was the worst?)

NOTE: IF THERE WAS AN EPISODE IN THE PAST YEAR, ASK ABOUT THAT EPISODE EVEN IF IT WAS NOT "THE WORST."

MDS CRITERIA

A. At least 5 of the following symptoms have each been present during the same two-week period (and represent a change from previous functioning); at least one of the symptoms was either (1) depressed mood, or (2) loss of interest or pleasure.

(1) depressed mood most of the day, nearly every day, as indicated either by subjective account or observation by others

? 1 2 3 33

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation by others of apathy most of the time)

? 1 2 3 34

If neither item (1) nor (2) is coded "3" go to ***Current Manic Syndrome,*** A 8

NOTE: IN EVALUATING DEPRESSIVE SXS, DO NOT INCLUDE SXS THAT ARE CLEARLY DUE TO A PHYSICAL CONDITION, MOOD-INCONGRUENT DELUSIONS OR HALLUCINATIONS, INCOHERENCE OR MARKED LOOSENING OF ASSOCIATIONS, OR SIMPLY PRODROMAL OR RESIDUAL SYMPTOMS OF SCHIZOPHRENIA.

FOCUS ON THE WORST EPISODE THAT THE SUBJECT CAN REMEMBER (OR ON ONE IN PAST YEAR)

During that time. . .

. . . did you lose or gain any weight? (How much?) (Were you trying to lose weight?) IF NO: How was your appetite? (What about compared to your usual appetite?) (Did you have to force yourself to eat?) (Eat [less/more] than usual?) (Was that nearly every day?)	(3) significant weight loss or weight gain when not dieting (e.g., more than 5% of body weight in a month) or decrease or increase in appetite nearly every day	?	1	2	3	35
. . how were you sleeping? (Trouble falling asleep, waking frequently, trouble staying asleep, waking too early, OR sleeping too much? How many hours a night compared to usual? Was that nearly every night?)	(4) insomnia or hypersomnia nearly every day	?	1	2	3	36
. . were you so fidgety or restless that you were unable to sit still? (Was it so bad that other people noticed it? Was that nearly every day?) IF NO: What about the opposite—talking or moving more slowly than is normal for you? (Was it so bad that other people noticed it? Was that nearly every day?)	(5) psychomotor agitation or retardation nearly every day (observable by others and not merely subjective feelings of restlessness or being slowed down)	?	1	2	3	37
. . what was your energy like? (Tired all the time? Nearly every day?)	(6) fatigue or loss of energy nearly every day	?	1	2	3	38
. . how did you feel about yourself? (Worthless?) (Nearly every day?) IF NO: What about feeling guilty about things you had done or not done? (Nearly every day?)	(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick) NOTE: CODE "1" OR "2" FOR LOW SELF-ESTEEM BUT NOT WORTHLESSNESS	?	1	2	3	39
. . did you have trouble thinking or concentrating? (What kinds of things did it interfere with?) (Nearly every day?) IF NO: Was it hard to make decisions about everyday things? (Nearly every day?)	(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)	?	1	2	3	40

During that time. . .

. . were things so bad that you were thinking a lot about death or that you would be better off dead? What about thinking of hurting yourself?

IF YES: Did you do anything to hurt yourself?

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

NOTE: CODE "1" IF ONLY SELF-MUTILATION W/O SUICIDAL INTENT

? 1 2 3 41

AT LEAST FIVE OF THE ABOVE SXS [A(1-9)] ARE CODED "3" AND AT LEAST ONE OF THESE IS ITEM (1) OR (2)

1 3 42

IF NOT ALREADY ASKED: Has there been any other time when you were (depressed/OWN EQUIVALENT) and had even more of the symptoms that I just asked you about?

→ IF NO: GO TO ***Current Manic Syndrome,*** A.8.

→ IF YES: RETURN TO ***Past Major Depressive Syndrome,*** A.4, AND INQUIRE ABOUT WORST EPISODE.

Continue

ETIOLOGIC ROLE OF AN ORGANIC FACTOR IN FULL DEPRESSIVE SYNDROME

Just before this began, were you physically ill? (What did the doctor say?)

Were you taking any medicines or street drugs? (Any change in the amount you were taking?)

IF YES TO ANY OF THESE QUESTIONS, DETERMINE IF THE DEPRESSIVE EPISODE WAS INITIATED AND MAINTAINED BY AN ORGANIC FACTOR

B.(1) It cannot be established that an organic factor initiated and maintained the disturbance.

? 1 3 43

R/O Organic Mood Syndrome

No organic etiology

IF ORGANIC FACTOR, DESCRIBE:

Established organic factors include: hypothyroidism, hyper- and hypoadrenocorticolism, substances such as reserpine, methyldopa, PCP and other hallucinogens.

Continue

DETERMINE IF THERE WAS A PERIOD OF DEPRESSED MOOD THAT WAS NOT INITIATED AND MAINTAINED BY AN ORGANIC FACTOR. IF SO, RETURN TO ***Past Major Depressive Syndrome,*** A.4, AND ASK ABOUT THAT EPISODE.

IF NOT, GO TO ***Current Manic Syndrome,*** A.8.

(Did this begin soon after someone close to you died?)

B.(2) The disturbance is not a normal reaction to the death of a loved one (Uncomplicated Bereavement). (NOTE: Morbid preoccupation with worthlessness, suicidal ideation, marked functional impairment or psychomotor retardation, or prolonged duration suggest bereavement complicated by Major Depression.)

? 1 3

1 → R.O. Uncomplicated Bereavement

3 → At least one episode not due to Uncomplicated Bereavement. Continue

DETERMINE IF THERE WAS A PERIOD OF DEPRESSED MOOD THAT WAS NOT DUE TO UNCOMPLICATED BEREAVEMENT. IF SO, RETURN TO ***Past Major Depressive Syndrome*** A.4, AND ASK ABOUT THAT EPISODE.

IF NOT, GO TO ***Current Manic Episode,*** A.8.

MAJOR DEPRESSIVE SYNDROME CRITERIA A AND B ARE CODED "3"

1 3

1 → Go to ***Current Manic Syndrome,*** A.8

3 → Past Major Depressive Syndrome

How many separate times have you been (depressed/OWN EQUIVALENT) nearly every day for at least two weeks and had several of the symptoms that you described, like (SXS OF WORST EPISODE)?

Total number of episodes of Major Depressive Syndrome (CODE 99 IF TOO NUMEROUS OR INDISTINCT TO COUNT) — —

How old were you when you first had a lot of these symptoms for at least two weeks?

Age at onset of first unequivocal Major Depressive Syndrome (CODE 99 IF UNKNOWN) — —

Current Manic Syndrome

MANIC SYNDROME CRITERIA

IF THOROUGH OVERVIEW OF PRESENT ILLNESS PROVIDES NO BASIS FOR SUSPECTING A CURRENT MANIC SYNDROME, CHECK HERE ____ AND GO TO ***Past Manic Syndrome,*** A.11. 50

In the last month, has there been a period of time when you were feeling so good or hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble? (Did anyone say you were manic?) (Was that more than just feeling good?)

IF NO: What about a period of time when you were so irritable that you would shout at people or start fights or arguments?

(Did you find yourself yelling at people you didn't really know?)

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood. ? 1 2 3 51

Go to '*Past Manic Syndrome,*' A.11

DATE:

What was that like?

How long did that last?

IF IRRITABLE MOOD ONLY, CHECK HERE AFTER CODING "3" ABOVE ____ 52

When were you the most (OWN EQUIVALENT FOR EUPHORIA OR IRRITABILITY)?

FOR THE WORST PERIOD OF CURRENT EPISODE, ASK ABOUT ASSOCIATED SXS

During this time . . .

B. During the period of mood disturbance, at least three of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

. . how did you feel about yourself?

(More self-confident than usual?)

(Any special powers or abilities?)

(1) inflated self-esteem or grandiosity ? 1 2 3 53

. . did you need less sleep than usual?

IF YES: Did you not feel tired?

(2) decreased need for sleep, e.g., feels rested after only three hours of sleep ? 1 2 3 54

. . were you more talkative than usual? (Did people have trouble stopping you or understanding you? Did people have trouble getting a word in edgewise?)

(3) more talkative than usual or pressure to keep talking ? 1 2 3 55

. . were your thoughts racing through your head?

(4) flight of ideas or subjective experience that thoughts are racing ? 1 2 3 56

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

. . did you have trouble concentrating because any little thing going on around you could get you off the track?	(5) distractibility, i.e., attention too easily drawn to unimportant or irrelevant external stimuli	?	1	2	3	57
. . how did you spend your time? (Work, friends, hobbies?) (Were you so active that your friends or family were concerned about you?) IF NO INCREASED ACTIVITY: Were you physically restless? (How bad was it?)	(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation	?	1	2	3	58
. . did you do anything that could have caused trouble for you or your family? (Buying things you didn't need?) (Anything sexual that was unusual for you?) (Reckless driving?)	(7) excessive involvement in pleasurable activities which have a high potential for painful consequences that the person does not recognize, e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments NOTE: BECAUSE OF THE DIFFICULTY OF DISTINGUISHING NORMAL PERIODS OF GOOD MOOD FROM HYPOMANIA, REVIEW ALL ITEMS CODED "3" IN CRITERIA "A" AND "B" AND RECODE ANY EQUIVOCAL JUDGMENTS	?	1	2	3	59
	AT LEAST THREE "B" SXS ARE CODED "3" (FOUR IF MOOD ONLY IRRITABLE)		1		3	60
			Go to "Past Manic Syndrome," A 11			
IF NOT KNOWN: At that time, did you have serious problems at home or at work (school) because you were (SYMPTOMS) or did you have to be admitted to the hospital?	C. Mood disturbance sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others. DESCRIBE:		1		3	61
			Unequivocal Hypomanic		Manic	
			Continue on next page			

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

DETERMINE POSSIBLE ETIOLOGIC ROLE OF AN ORGANIC FACTOR IN MANIC OR HYPOMANIC SYNDROME

Just before this began, were you taking any street drugs or medicines? (Any change in the amount you were taking?) Were you physically ill?

IF YES TO ANY OF THESE QUESTIONS, DETERMINE IF THE MANIC EPISODE WAS INITIATED AND MAINTAINED BY AN ORGANIC FACTOR.

D. It cannot be established that an organic factor initiated and maintained the disturbance. NOTE: Somatic antidepressant treatment (e.g., drugs, ECT) that apparently precipitates a mood disturbance should not be considered an etiologic organic factor.

? 1 3 62

R/O Organic Mood Syndrome — Go to **'Past Manic Syndrome,'** A 11

No organic etiology — Continue

IF ORGANIC FACTOR, DESCRIBE:

Established organic factors include: hyperthyroidism, substances such as stimulants and cocaine.

MANIC SYNDROME CRITERIA A, B, C, AND D ARE CODED "3"

1 3 63

Go to **'Past Manic Syndrome,'** A 11

Current Manic Syndrome

NOTE: CODE "1" IF CURRENT HYPOMANIC SYNDROME ONLY

How many separate times were you (high/OWN EQUIVALENT) and had [ACKNOWLEDGED MANIC SYMPTOMS] for a period of time (or were hospitalized)?

Number of episodes of manic syndrome, including current (CODE 99 IF TOO INDISTINCT OR NUMEROUS TO COUNT) — — 64-65

How old were you when you first had serious problems or had to go to the hospital because you were (manic/high/OWN EQUIVALENT)?

Age at onset of first manic syndrome (CODE 99 IF UNKNOWN) — — 66-67

Go to **'Psychotic Symptoms,'** B 1

Past Manic Syndrome

MANIC SYNDROME CRITERIA

NOTE: IF CURRENTLY ELEVATED MOOD BUT FAILS TO MEET FULL CRITERIA FOR A MANIC SYNDROME, SUBSTITUTE THE PHRASE "Has there ever been *another* time . . ." FOR EACH OF THE SCREENING QUESTIONS BELOW.

Have you ever had a time when you were feeling so good or hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?

(Did anyone say you were manic?) (Was that more than just feeling good?)

IF NO: What about a period of time when you were so irritable that you would shout at people or start fights or arguments? (Did you find yourself yelling at people you didn't really know?)

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood.

? 1 2 3 :6

Go to "Dysthymia," A 14

When was that?

DATE:

What was it like?

How long did it last?

Have you had more than one time like that?

IF YES: Which time were you the most (high/OWN EQUIVALENT)?

IF IRRITABLE MOOD ONLY, CHECK HERE AFTER CODING "3" ABOVE ___ :7

B. During the period of mood disturbance, at least three of the following symptoms have persisted (four if the mood was only irritable) and were present to a significant degree:

During that time . . .

. . how did you feel about yourself?

(More self-confident than usual?)

(Any special powers or abilities?)

(1) inflated self-esteem or grandiosity ? 1 2 3 :8

. . did you need less sleep than usual?

IF YES: Did you not feel tired?

(2) decreased need for sleep, e.g., feels rested after only three hours of sleep ? 1 2 3 :9

. . were you more talkative than usual? (Did people have trouble stopping you or understanding you? Did people have trouble getting a word in edgewise?)

(3) more talkative than usual or pressure to keep talking ? 1 2 3 :0

. . were your thoughts racing through your head?	(4) flight of ideas or subjective experience that thoughts are racing	?	1	2	3	21
. . did you have trouble concentrating because any little thing going on around you could get you off the track?	(5) distractibility, i.e., attention too easily drawn to unimportant or irrelevant external stimuli	?	1	2	3	22
. . how did you spend your time? (Work, friends, hobbies?) (Were you so active that your friends or family were concerned about you?) IF NO INCREASED ACTIVITY: Were you physically restless? (How bad was it?)	(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation	?	1	2	3	23
. . did you do anything that could have caused trouble for you or your family? (Buying things you didn't need?) (Anything sexual that was unusual for you?) (Reckless driving?)	(7) excessive involvement in pleasurable activities which have a high potential for painful consequences that the person does not recognize, e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments NOTE: BECAUSE OF THE DIFFICULTY OF DISTINGUISHING NORMAL PERIODS OF GOOD MOOD FROM HYPOMANIA, REVIEW ALL ITEMS CODED "3" IN CRITERIA A AND B AND RECODE ANY EQUIVOCAL JUDGMENTS.	?	1	2	3	24
	AT LEAST THREE "B" SXS ARE CODED "3" (FOUR IF MOOD ONLY IRRITABLE)		1		3	25

IF NOT ALREADY ASKED: Has there been any other time when you were (hyper/irritable/OWN EQUIVALENT) and had even more of the symptoms that I just asked you about?

→ IF NO: GO TO ***Dysthymia,*** A.14.

→ IF YES: RETURN TO ***Past Manic Syndrome,*** A.11, AND INQUIRE ABOUT WORST EPISODE.

Continue

IF NOT KNOWN: At that time, did you have serious problems at home or at work (school) because you were (SYMPTOMS) or did you have to be admitted to the hospital?

C. Mood disturbance sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others.

1 Unequivocal Hypomanic — 3 Manic — 26

IF NOT ALREADY ASKED: Has there been any other time when you were (high/OWN EQUIVALENT) and had (ACKNOWLEDGED MANIC SYMPTOMS) and you got into trouble with people or were hospitalized?

→ IF YES: RECODE CRITERION C as "3"

→ IF NO: CONTINUE WITH NEXT ITEM

3 Continue

Just before this began, were you taking any street drugs or medicines? (Any change in the amount you were taking?) Were you physically ill?

IF YES TO ANY OF THESE QUESTIONS, DETERMINE IF THERE WAS AT LEAST ONE MANIC EPISODE THAT WAS NOT INITIATED AND MAINTAINED BY AN ORGANIC FACTOR.

D. It cannot be established that an organic factor initiated and maintained the disturbance. NOTE: Somatic antidepressant treatment (e.g., drugs, ECT) that apparently precipitates a mood disturbance should not be considered an etiologic organic factor.

IF ORGANIC FACTOR, DESCRIBE:

Established organic factors include: hyperthyroidism, substances such as stimulants and cocaine.

? 1 R/O Organic Mood Syndrome — 3 No organic etiology — 27

DETERMINE IF THERE WAS A PERIOD OF ELEVATED OR IRRITABLE MOOD THAT WAS NOT INITIATED OR MAINTAINED BY AN ORGANIC FACTOR. IF SO, RETURN TO ***Past Manic Syndrome,*** A.11, AND INQUIRE ABOUT THAT EPISODE.

IF NOT, GO TO ***Dysthymia,*** A.14.

3 Continue

MANIC SYNDROME CRITERIA A, B, C, AND D ARE CODED "3"

NOTE: CODE "1" IF PAST HYPOMANIC SYNDROMES ONLY.

1 Go to *Psychotic SXS,* B 1 — 3 Past Manic Syndrome — 28

How many separate times were you (high/OWN EQUIVALENT) and had several of these problems for a period of time (or were hospitalized)?

Total number of episodes of manic syndrome (CODE 99 IF TOO INDISTINCT OR NUMEROUS TO COUNT) — — — 29 30

How old were you when you first had serious problems or had to go to the hospital because you were (manic/high/OWN EQUIVALENT)?

Age at onset of manic syndrome (CODE 99 IF UNKNOWN) — — — 31 32

Go to *Psychotic SXS,* B 1

Dysthymia
(CURRENT ONLY)

DYSTHYMIA CRITERIA

IF: THE OVERVIEW INDICATES THAT A CHRONIC PSYCHOTIC DISORDER IS LIKELY, OR THERE HAVE BEEN ONE OR MORE MAJOR DEPRESSIVE SYNDROMES PRESENT FOR MORE THAN 50% OF THE PAST TWO YEARS, OR A HYPOMANIC OR MANIC EPISODE HAS EVER BEEN PRESENT, CHECK ____ AND GO TO ***Psychotic Symptoms,*** B.1. 33

→ IF NO MAJOR DEPRESSIVE SYNDROME IN PAST TWO YEARS: For the past couple of years, have you been bothered by depressed mood most of the day, more days than not? (More than half the time?)

IF YES: What was that like?

A. Depressed mood for most of the day, more days than not, as indicated either by subjective account or observation by others, for at least the past two years [or the two years preceding the most recent Major Depressive episode plus the time since the Major Depressive episode ended] ? 1 2 3 34

Go to **'Psychotic SXS,'** B.1

→ IF CURRENT MAJOR DEPRESSIVE SYNDROME: Let's review when you first had most of the symptoms of (CURRENT MAJOR DEPRESSIVE SYNDROME). For the two years prior to (BEGINNING DATE), were you bothered by depressed mood, most of the day, more days than not? (More than half the time?)

RECORD DATE WHEN FIRST MET CRITERIA FOR CURRENT MAJOR DEPRESSIVE SYNDROME: _____

→ FOR A PAST MAJOR DEPRESSIVE SYNDROME DURING THE PAST TWO YEARS: Let's review when you first had most of the symptoms of (PAST MAJOR DEPRESSIVE SYNDROME) and the point at which you no longer had most of the symptoms. Since (DATE OF NO LONGER MEETING CRITERIA), have you still been bothered by depressed mood, so that you have been depressed for most of the day, more days than not?

IF YES: For the two years prior to (DATE OF BEGINNING OF PAST MAJOR DEPRESSIVE SYNDROME), were you bothered by depressed mood, most of the day, more days than not? (More than half the time?)

RECORD DATE WHEN FIRST MET CRITERIA FOR PAST MAJOR DEPRESSIVE SYNDROME: _____

RECORD DATE WHEN NO LONGER MET CRITERIA FOR PAST MAJOR DEPRESSIVE SYNDROME: _____

During these periods of (OWN EQUIVALENT FOR CHRONIC DEPRESSION), do you often. . .

B. Presence, while depressed, of at least two of the following:

. . lose your appetite? (What about overeating?)

(1) poor appetite or overeating ? 1 2 3 35

. . have trouble sleeping or sleep too much?

(2) insomnia or hypersomnia ? 1 2 3 36

. . have little energy to do things or feel tired a lot?

(3) low energy or fatigue ? 1 2 3 37

. . feel down on yourself? (Feel worthless, or a failure?)	(4) low self-esteem	? 1 2 3	38
. . have trouble concentrating or making decisions?	(5) poor concentration or difficulty making decisions	? 1 2 3	39
. . feel hopeless?	(6) feelings of hopelessness	? 1 2 3	40
	AT LEAST TWO "B" SYMPTOMS ARE CODED "3"	1 3 → Go to "Psychotic SXS," 9.1	41
What is the longest period of time, during this period of long-lasting depression, that you felt OK? (NO DYSTHYMIC SYMPTOMS)	C. [For the two-year period of chronic depressed mood], never without these symptoms for more than two months at a time. CODE "1" IF NORMAL MOOD FOR AT LEAST TWO MONTHS AT A TIME.	? 1 2 3 → Go to "Psychotic SXS," 9.1	42
How long have you been feeling this way? (When did this begin?) COMPARE ONSET OF DYSTHYMIC SXS WITH DATES OF PAST MAJOR DEPRESSIVE SYNDROMES TO DETERMINE IF THERE WERE ANY MAJOR DEPRESSIVE SYNDROMES DURING FIRST TWO YEARS OF DYSTHYMIA.	D. (1) No clear evidence of a Major Depressive Episode during first two years of the disturbance. NOTE: CODE "3" IF NO PAST MAJOR DEPRESSIVE EPISODES OR IF MAJOR DEPRESSIVE EPISODES ARE NOT PRESENT DURING FIRST TWO YEARS.	? 1 2 3 → Go to "Psychotic SXS," 9.1	43
	Age at onset of current Dysthymia (CODE 99 IF UNKNOWN)	— —	44 45
IF A MAJOR DEPRESSIVE SYNDROME PRECEDED DYSTHYMIC SXS: Now I want to know whether you got completely back to your usual self after that (MAJOR DEPRESSIVE SYNDROME) you had (DATE), before this long period of being mildly depressed? (Were you back to your usual self for at least six months?)	D. (2) [If a Major Depressive syndrome *precedes* the two-year period of Dysthymia, then there must be an intervening period of at least six months of full remission, i.e., no significant signs or symptoms] NOTE: CODE "3" IF NO PRECEDING PAST MAJOR DEPRESSIVE EPISODES OR IF THERE WAS AT LEAST A SIX-MONTH PERIOD WITHOUT SYMPTOMS PRECEDING THE ONSET OF THE DYSTHYMIC SYMPTOMS.	? 1 2 3 → Go to "Psychotic SXS," 9.1	46
IF NOT ALREADY CLEAR: RETURN TO THIS ITEM AFTER COMPLETING THE PSYCHOTIC DISORDERS SECTION.	E. Not superimposed on a chronic psychotic disorder (e.g., Schizophrenia or Delusional Disorder). NOTE: CODE "3" IF NO CHRONIC PSYCHOTIC DISORDER OR IF NOT SUPERIMPOSED ON A CHRONIC PSYCHOTIC DISORDER.	? 1 3 → Go to "Psychotic SXS," 9.1; 3 → Not superimposed continue on next page	47

EXPLORE POSSIBLE ETIOLOGIC ROLE OF ORGANIC FACTORS

Have you been taking any street drugs or medicines during this time (the past two years)?

(Have you had a chronic physical illness during this time?)

F. It cannot be established that an organic factor initiated and maintained the disturbance.

IF ORGANIC FACTOR, DESCRIBE:

Established organic factors include: prolonged administration of reserpine or methyldopa, chronic hallucinogen abuse, recurrent withdrawal states, and chronic hypothyroidism.

? 1 3 48

1 → Go to "Psychotic SXS," B.1

3 → No organic etiology — continue

DYSTHYMIA CRITERIA A, B, C, D, E, AND F ARE CODED "3" 1 3 49

1 → Go to "Psychotic SXS," B.1

3 → Dysthymia

Indicate Type (revise at end of interview if necessary): — 50

1 Primary (the mood disturbance is not related to a preexisting, chronic, non-mood Axis I or Axis III disorder, e.g., Anorexia Nervosa, Somatization Disorder, a Psychoactive Substance Use Disorder, an Anxiety Disorder, or rheumatoid arthritis)

2 Secondary (the mood disturbance is apparently related to a preexisting, chronic, non-mood Axis I or Axis III disorder)

B/C. "Psychotic Screening"

25 duplicate 0
1-2 3-14 15

THIS MODULE IS FOR CODING PSYCHOTIC AND ASSOCIATED SXS THAT HAVE BEEN PRESENT AT ANY POINT IN THE PERSON'S LIFETIME. (IN SOME CLINICAL AND RESEARCH SETTINGS, SUBJECTS WITH A HISTORY OF NON-ORGANIC PSYCHOTIC SYMPTOMS, OR A HISTORY OF NON-ORGANIC PSYCHOTIC SYMPTOMS THAT OCCUR IN A CONTEXT OTHER THAN A MOOD DISORDER, WILL BE EXCLUDED).

FOR ALL PSYCHOTIC AND ASSOCIATED SYMPTOMS CODED "3," DETERMINE WHETHER THE SYMPTOM IS "NOT ORGANIC," OR WHETHER THERE IS A POSSIBLE OR DEFINITE ORGANIC CAUSE. THE FOLLOWING QUESTIONS MAY BE USEFUL IF THE OVERVIEW HAS NOT ALREADY PROVIDED THE INFORMATION:

When you were (PSYCHOTIC SXS), were you taking any drugs or medicines? Drinking a lot? Physically ill?

→ IF HAS NOT ACKNOWLEDGED PSYCHOTIC SXS: Now I am going to ask you about unusual experiences that people sometimes have.

→ IF HAS ACKNOWLEDGED PSYCHOTIC SXS: You have told me about (PSYCHOTIC EXPERIENCES). Now I am going to ask you more about those kinds of things.

DELUSIONS

False personal belief(s) based on incorrect inference about external reality and firmly sustained in spite of what almost everyone else believes and in spite of what constitutes incontrovertible and obvious proof or evidence to the contrary. Code overvalued ideas [unreasonable and sustained beliefs that are maintained with less than delusional intensity] as "2."

NOTE: A SINGLE DELUSION MAY BE CODED "3" ON MORE THAN ONE OF THE FOLLOWING ITEMS.

Did it ever seem that people were talking about you or taking special notice of you?

What about receiving special messages from the TV, radio, or newspaper, or from the way things were arranged around you?

Delusions of reference, i.e., personal significance is falsely attributed to objects or events in environment

DESCRIBE:

? 1 2 3 16

1 3 17
Poss def organic Not org

What about anyone going out of the way to give you a hard time, or trying to hurt you?

Persecutory delusions, i.e., the individual (or his or her group) is being attacked, harassed, cheated, persecuted, or conspired against

DESCRIBE:

? 1 2 3 18

1 3 19
Poss def organic Not org

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

Did you ever feel that you were especially important in some way, or that you had powers to do things that other people couldn't do?

Grandiose delusions, i.e., content involves exaggerated power, knowledge or importance

DESCRIBE:

? 1 2 3 20

1 3 21

Poss def organic Not org

Did you ever feel that parts of your body had changed or stopped working? (What did the doctor say?)

Somatic delusions, i.e., content involves change or disturbance in body functioning

DESCRIBE:

? 1 2 3 22

1 3 23

Poss def organic Not org

(Did you ever feel that you had committed a crime or done something terrible for which you should be punished?)

Other delusions, e.g., delusions of guilt, jealousy, nihilism, poverty

DESCRIBE:

? 1 2 3 24

1 3 25

Poss def organic Not org

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

Hallucinations

HALLUCINATIONS (PSYCHOTIC)
A sensory perception without external stimulation of the relevant sensory organ. (CODE "2" FOR HALLUCINATIONS THAT ARE SO TRANSIENT AS TO BE WITHOUT DIAGNOSTIC SIGNIFICANCE)

Did you ever hear things that other people couldn't hear, such as noises, or the voices of people whispering or talking? (Were you awake at the time?)

Auditory hallucinations when fully awake and heard either inside or outside of head

DESCRIBE:

? 1 2 3 35

1 Poss de' organic 3 Not org 36

Did you ever have visions or see things that other people couldn't see? (Were you awake at the time?)

NOTE: DISTINGUISH FROM AN ILLUSION, I.E., A MISPERCEPTION OF A REAL EXTERNAL STIMULUS.

Visual hallucinations

DESCRIBE:

? 1 2 3 40

1 Poss de' organic 3 Not org 41

What about strange sensations in your body or on your skin?

Tactile hallucinations, e.g., electricity

DESCRIBE:

? 1 2 3 42

1 Poss de' organic 3 Not org 43

(What about smelling things that other people couldn't smell?)

Other hallucinations, e.g., gustatory, olfactory

DESCRIBE:

? 1 2 3 44

1 Poss de' organic 3 Not org 45

ANY ITEM CODED "3" IN "NOT ORG" SECTION

? 1 3 46

Go to next module

A nonorganic psychotic sx has been present

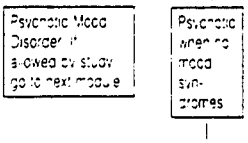
? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

IF A MAJOR DEPRESSIVE OR MANIC SYNDROME HAS EVER BEEN PRESENT: Has there ever been a time when you had (PSYCHOTIC SXS) and you were not (OWN EQUIVALENT FOR DEPRESSION AND/OR MANIA)?

Psychotic symptoms occur at times other than during mood syndromes

NOTE: CODE "3" IF NO MOOD SYNDROMES OR PSYCHOTIC SXS W/O MOOD SYNDROMES. CODE "1" ONLY IF PSYCHOTIC SYMPTOMS OCCUR EXCLUSIVELY DURING UNEQUIVOCAL MOOD SYNDROMES.

? 1 3 47



EXPLORE DETAILS WITH SUBJECT AND THEN DESCRIBE DIAGNOSTIC SIGNIFICANCE (E.G., "PSYCHOACTIVE SUBSTANCE-INDUCED PSYCHOTIC DISORDER," "SCHIZOPHRENIA OR OTHER CHRONIC PSYCHOTIC DISORDER," OR "A TRANSIENT SX OF A NON-PSYCHOTIC DISORDER, SUCH AS BORDERLINE PERSONALITY DISORDER OR POST-TRAUMATIC STRESS DISORDER"):

D. *Mood Disorders* (OTHER THAN DYSTHYMIA)

[DYSTHYMIA HAS ALREADY BEEN CODED IN MODULE A. IF NO OTHER MOOD SYNDROMES, SKIP TO NEXT MODULE.]

IF: THERE HAS NEVER BEEN A **MAJOR DEPRESSIVE EPISODE** (A.3 OR A.7), **OR A MANIC OR HYPOMANIC EPISODE** (A.10 OR A.13), CHECK HERE ____ AND SKIP TO NEXT MODULE.

IF: NO MANIC OR UNEQUIVOCAL HYPOMANIC EPISODE EVER, CHECK HERE ____ AND SKIP TO ***Major Depressive Syndrome,*** D.2.

AT LEAST ONE PURE MANIC EPISODE (I.E., **NOT** SUPERIMPOSED ON SCHIZOPHRENIA, SCHIZOPHRENIFORM DISORDER, DELUSIONAL DISORDER, OR PSYCHOTIC DISORDER NOS). NOTE: CIRCLE "1" IF ONLY HYPOMANIC EPISODES. ? 1 3

Bipolar Disorder

Subtype of Most Recent Episode

1 Manic
2 Depressed
3 Mixed [i.e., meets full criteria for both Manic and Major Depressive Episodes (except for the duration requirement of two weeks for depressive symptoms), intermixed or rapidly alternating every few days, and prominent depressive symptoms lasting at least a full day]

GO TO ***Mood Chronology,*** D.3

OTHER BIPOLAR DISORDER (Indicate type by circling choice below)

1—Manic Episode superimposed on Delusional Disorder, residual Schizophrenia or Psychotic Disorder NOS
2—Hypomanic Episode(s) with Major Depressive Episode(s) ("Bipolar II")
3—Intermittent hypomanic episodes
4—Cyclothymia
5—Other (describe): _____

CHECK HERE ____ IF PRESENT IN LAST MONTH: GO TO ***Past Five Years,*** D.5

•Major Depressive Syndrome• ? 1 3 22

AT LEAST ONE PURE MAJOR DEPRESSIVE EPISODE (I.E., **NOT** SUPERIMPOSED ON SCHIZOPHRENIA, SCHIZOPHRENIFORM DISORDER, DELUSIONAL DISORDER, OR PSYCHOTIC DISORDER NOS)

Major depressive

Go to "Mood Chronology," D.3

DEPRESSIVE DISORDER SUPERIMPOSED ON CHRONIC PSYCHOTIC DISORDER (for Major Depressive Episodes superimposed on chronic or intermittent psychotic conditions). Note: Other conditions that in DSM-III-R would be classified as Depressive Disorder NOS, e.g., intermittent dysthymic symptoms, should be noted on the SCID scoresheet as "Other DSM-III-R Axis I Disorder."

CHECK HERE ____ IF PRESENT IN LAST MONTH: GO TO **•Past Five Years,•** D.5 23

Mood Chronology

IF UNCLEAR: During the past month, have you had (DEPRESSIVE OR MANIC SXS CODED "3")?	Has met symptomatic criteria for manic syndrome (criteria A and B) or depressive syndrome in the past month. NOTE: If there has been a previous major Mood Disorder (i.e., Major Depression or Bipolar Disorder), then the current episode need not meet full criteria.	?	1	3	
When did you last have (EITHER DEPRESSED MOOD, OR EUPHORIC OR IRRITABLE MOOD) (i.e., most recent episode)?	Number of months prior to interview when last had persistently depressed, or euphoric or irritable mood	— — —			

SUBCLASSIFICATION OF CURRENT PARTIAL OR FULL REMISSION:

→ IF BIPOLAR DISORDER:

6 In Partial Remission: Full criteria were previously, but are not currently, met; some signs or symptoms of the disturbance have persisted.

7 In Full Remission: During the past six months no significant signs or symptoms of the disturbance.

→ IF MAJOR DEPRESSION:

6 In Partial Remission: Intermediate between "In Full Remission" and "Mild." **AND** no previous Dysthymia. [If Major Depressive Episode was superimposed on Dysthymia, the diagnosis of Dysthymia alone is given once the condition has returned to baseline Dysthymia.]

7 In Full Remission: During the past six months no significant signs or symptoms of the disturbance. [Note: Symptoms of Dysthymia may be present.]

GO TO ***Past Five Years,*** D. 5.

CONTINUE ON NEXT PAGE.

SUBCLASSIFICATION OF CURRENT EPISODE (WORST WEEK PAST MONTH):
(Additional questions regarding impairment may be necessary.)

→ IF MOST RECENT EPISODE IS HYPOMANIC, MANIC OR MIXED:

1 Mild: Meets minimum symptom criteria for a manic or hypomanic episode (or a new episode that almost meets symptom criteria if has had a previous manic episode).

2 Moderate: Extreme increase in activity or impairment in judgment.

3 Severe, but without psychotic features: Almost continual supervision is required in order to prevent physical harm to self or others.

4 Mood-congruent psychotic features: Delusions or hallucinations whose content is entirely consistent with the typical manic themes of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person.

5 Mood-incongruent psychotic features: Either (a) or (b):

(a) Delusions or hallucinations whose content does not involve the typical manic themes of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person. Included are such symptoms as persecutory delusions, thought insertion, and delusions of being controlled.

(b) Any catatonic symptoms, e.g., stupor, mutism, negativism, or posturing.

→ IF MOST RECENT EPISODE IS DEPRESSED:

1 Mild: Few, if any, symptoms in excess of those required to make the diagnosis **AND** symptoms result in only minor impairment in occupational functioning or in usual social activities or relationships with others [**OR** (see SCID-P)].

2 Moderate: Symptoms or functional impairment intermediate between "mild" and "severe."

3 Severe, but without psychotic features: Several symptoms in excess of those required to make the diagnosis **AND** symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.

4 Mood-congruent psychotic features: Delusions or hallucinations whose content is entirely consistent with the typical depressive themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment.

5 Mood-incongruent psychotic features: Delusions or hallucinations whose content does not involve typical depressive themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment. Included here are such symptoms as persecutory delusions, thought insertion, thought broadcasting, and delusions of control.

Past Five Years

During the past five years, how much of the time have you been unusually (EUPHORIC/IRRITABLE AND/OR DEPRESSED/NOT INTERESTED IN THINGS)?

Would you say . . . [CODE DESCRIPTIONS]?

Approximate percentage of time during past five years that euphoric/irritable AND/OR depressed mood AND/OR loss of interest were present.

1 Not at all (0%)

2 Rarely (e.g., 5–10%)

3 A significant minority of the time (e.g., 20–30%)

4 About half the time

5 A significant majority of the time (e.g., 70–80%)

6 Almost all the time (e.g., 90–100%)

9 Unknown

E. *Psychoactive Substance Use Disorders*

Duplicate

ALCOHOL DEPENDENCE OR ABUSE (LIFETIME)

What are your drinking habits like? (How much do you drink?)

Was there ever a period in your life when you drank too much? (Has alcohol ever caused problems for you?)

IF YES: What problems did it cause?

Has anyone ever objected to your drinking?

IF YES: Why?

IF NO SUGGESTION THAT EVER DRANK ALCOHOL EXCESSIVELY OR HAD ALCOHOL-RELATED PROBLEMS, CHECK HERE ____ AND SKIP TO ***Non-Alcohol PSUD,*** E.6.

16

→ IF HAS ACKNOWLEDGED HAVING PROBLEMS: When in your life were you having the most problems because of your drinking? (How long did that period last?)

→ IF HAS NOT ACKNOWLEDGED HAVING PROBLEMS BUT DRANK EXCESSIVELY: When in your life were you drinking the most? (How long did that period last?)

Now I am going to ask you several questions about that time.

How often were you drinking (then)? What were you drinking? How much?

ALCOHOL DEPENDENCE CRITERIA

A. At least three of the following:

Did you often find that when you started drinking you ended up drinking much more than you were planning to? IF NO: What about drinking for a much longer period of time than you were planning to?	(1) Alcohol often taken in larger amounts OR over a longer period than the person intended	?	1	2	3	17
Did you try to cut down or stop drinking alcohol? IF YES: Did you ever actually stop drinking altogether? (How many times did you try to cut down or stop altogether?)	(2) Persistent desire OR one or more unsuccessful efforts to cut down or control alcohol use	?	1	2	3	18

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

IF UNCLEAR: Did you want to stop or cut down? IF YES: Is this something you kept worrying about?						
Did you spend a lot of time drinking, being high, or hung over?	(3) A great deal of time spent in activities necessary to get alcohol, taking alcohol, or recovering from its effects	?	1	2	3	19
Did you ever drink in a situation in which it might have been dangerous to drink at all? (Did you ever drive while you were really too drunk to drive?) (How often?) IF NO: What about a time when you were often intoxicated or high or very hungover while you were doing something important, like being at school, or work, or taking care of children? IF NO: What about missing something important, like staying away from school or work or missing an appointment because you were intoxicated, high, or very hungover?	(4)(a) Recurrent use when substance use is physically hazardous (e.g., drives when intoxicated) OR (4)(b) Frequent intoxication or withdrawal symptoms when expected to fulfill major role obligations at work, school, or home (e.g., doesn't go to work because hung over, goes to school or work high, intoxicated while taking care of children)	?	1	2	3	20
Did you drink so often that you started to drink instead of working or spending time at hobbies or with your family or friends?	(5) Important social, occupational, or recreational activities given up or reduced because of alcohol use	?	1	2	3	21
IF NOT ALREADY KNOWN: Did your drinking cause problems with other people, such as with family members or people at work? IF NOT ALREADY KNOWN: Did your drinking cause significant psychological problems, like making you depressed? IF NOT ALREADY KNOWN: Did your drinking ever cause significant physical problems or make a physical problem worse? (Was it more than just a simple hangover?) IF YES TO ANY OF ABOVE: Did you keep on drinking anyway?	(6) Continued alcohol use despite knowledge of having a persistent or recurrent social, [significant] psychological, or [significant] physical problem that is caused or exacerbated by the use of alcohol	?	1	2	3	22

Did you find that you needed to drink a lot more in order to get high than you did when you first started drinking? (Could you drink a lot more than most people without really getting drunk?) IF YES: How much more? IF NO: What about finding that when you drank the same amount, it had much less effect than before?	(7) Marked tolerance: need for markedly increased amounts of alcohol (i.e., at least a 50% increase) in order to achieve intoxication or desired effect. OR markedly diminished effect with continued use of the same amount	?	1	2	3	23
Did you ever have the shakes when you cut down or stopped drinking (that is, your hands shook so much that other people would have been able to notice it)?	(8) Characteristic withdrawal symptoms (SEE LIST OF WITHDRAWAL SYMPTOMS BELOW). (Do not include simple "hang-over.")	?	1	2	3	24
IF "2" OR "3" ON PREVIOUS ITEM: After not drinking for a few hours or more, did you often drink to keep yourself from getting the shakes or becoming sick? IF NO: What about drinking to stop the shakes or to stop feeling sick?	(9) Alcohol often taken to relieve or avoid withdrawal symptoms NOTE: CODE "1" IF RATED "1" ON PREVIOUS ITEM	?	1	2	3	25
	AT LEAST ONE "A" ITEM CODED "3"		1		3	26
IF UNCLEAR: For how long a time were you having (SXS OF ALCOHOL DEPENDENCE OR ABUSE)?	B. Some symptoms of the disturbance [clustered together] have persisted for at least one month, or have occurred repeatedly over a longer period of time.	?	1		3	27

Go to 'Non-alcohol PSUD,' E6

Go to 'Non-alcohol PSUD,' E6

Alcohol Dependence: At least three "A" items are coded "3"

Alcohol Abuse: Does not meet criteria for Dependence but does meet either (1) or (2) below:

(1) continued use despite knowledge of having a persistent or recurrent social, occupational, [significant] psychological, or [significant] physical problem that is caused or exacerbated by use of alcohol. NOTE: REFER TO ITEM (6) ON E.2

(2) recurrent use in situations in which use is physically hazardous (e.g., driving while intoxicated) NOTE: REFER TO ITEM (4)(a) ON E.2

Neither Dependence nor Abuse:

? 1 2 3 28

Go to "Non-alcohol PSUD," E.6

Alcohol abuse

Check here ____ if meets criteria for abuse in past month

GO TO **"Non-Alcohol PSUD,"** E.6.

Alcohol Dependence 29

Continue on next page

? = inadequate information 1 = no disorder 2 = abuse 3 = dependence

CHRONOLOGY OF ALCOHOL DEPENDENCE

When did you last have problems with alcohol?

NOTE SEVERITY OF DEPENDENCE FOR WORST WEEK OF PAST MONTH
(Additional questions about the effect of alcohol on social and occupational functioning may be necessary.)

1 Mild: Few, if any, symptoms in excess of those required to make the diagnosis, and the symptoms result in no more than mild impairment in occupational functioning, or in usual social activities or relationships with others.

2 Moderate: Symptoms or functional impairment between "mild" and "severe."

3 Severe: Many symptoms in excess of those required to make the diagnosis, and the symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.

4 In Partial Remission: During the past six months, some use of alcohol and some symptoms of dependence.

5 In Full Remission: During the past six months, either no use of alcohol, or use of alcohol and no symptoms of dependence.

Number of months prior to interview when last had some symptoms of dependence ___ ___ ___

ALCOHOL DEPENDENCE PAST FIVE YEARS

During the past five years, how much of the time have you had (SXS OF DEPENDENCE)?

Would you say . . . [CODE DESCRIPTIONS]?

Approximate percentage of time during past five years that any symptoms of Alcohol Dependence were present

1 Not at all (0%)

2 Rarely (e.g., 5–10%)

3 A significant minority of the time (e.g., 20–30%)

4 About half the time

5 A significant majority of the time (e.g., 70–80%)

6 Almost all the time (e.g., 90–100%)

9 Unknown

How old were you when you first had (LIST OF ALCOHOL DEPENDENCE SXS CODED "3")?

Age at onset of Alcohol Dependence (CODE 99 IF UNKNOWN) ___ ___

"Non-Alcohol Psychoactive Substance Use Disorders" (LIFETIME DEPENDENCE OR ABUSE)

Now I am going to ask you about your use of drugs or medicines.

SHOW DRUG LIST TO SUBJECT. (Drug list appears on inside back cover—tear off front and back cover, and give patient back cover only.)

Have you ever taken any of these to get high, to sleep better, to lose weight, or to change your mood?

REFERRING TO LIST ON NEXT PAGE, DETERMINE LEVEL OF DRUG USE USING GUIDELINES BELOW

GUIDELINES FOR RATING LEVEL OF DRUG USE:

→ **IF NO DRUGS IN THAT GROUP EVER USED OR USED ONLY ONCE, CIRCLE "1" FOR DRUG GROUP ON E.7.**

→ **FOR EACH DRUG GROUP EVER USED:** Either (1) or (2):

→ IF STREET DRUG: When were you taking (DRUG) the most?

(Has there ever been a time when you took it more than ten times in a month?)

(1) has ever taken street drug more than 10 times in a one-month period

→ IF PRESCRIBED: Did you ever get hooked [become dependent on] (PRESCRIBED DRUG)?

IF NO: Did you ever take much more of it than was prescribed?

(2) reports becoming dependent on a prescribed drug OR using much more of it than was prescribed

→ **IF NEITHER ITEM (1) NOR (2) IS TRUE, CIRCLE "2" FOR DRUG GROUP ON E.7.**

→ **IF EITHER ITEM (1) OR (2) IS TRUE, CIRCLE "3" FOR DRUG GROUP ON E.7.**

CIRCLE THE NAME OF EACH DRUG EVER USED (OR WRITE IN NAME IF "OTHER")	RECORD PERIOD OF HEAVIEST USE (AGE OR DATE, AND DURATION)	INDICATE LEVEL OF USE (USE GUIDELINES, E.6)	
Sedatives-hypnotics-anxiolytics: Quaalude, Seconal, Valium, Xanax, Librium, barbiturates, Miltown, Ativan, Dalmane, Halcion, unspecified, or other: _____	_____	? 1 2 3	37
Cannabis: marijuana, hashish, THC, unspecified, or other: _____	_____	? 1 2 3	38
Stimulants: amphetamine, "speed," crystal meth, dexadrine, Ritalin, unspecified, or other: _____	_____	? 1 2 3	39
Opioids: heroin, morphine, opium, Methadone, Darvon, codeine, Percodan, Demerol, Dilaudid, unspecified, or other: _____	_____	? 1 2 3	40
Cocaine: intranasal, IV, freebase, crack, "speedball," unspecified, or other: _____	_____	? 1 2 3	41
Hallucinogens/PCP: LSD, mescaline, peyote, psilocybin, STP, mushrooms, PCP ("angel dust," "peace pill"), unspecified, or other: _____	_____	? 1 2 3	42
Other: steroids, "glue," ethyl chloride, nitrous oxide ("laughing gas"), amyl or butyl nitrate ("poppers"), Extasy, MDA, MDM, nonprescription sleep or diet pills, other: _____	_____	? 1 2 3	43
	ANY DRUG GROUPS CODED "2" OR "3"	1 → Go to next module	3 44
IF AT LEAST THREE DRUG GROUPS USED AND PERIOD OF INDISCRIMINATE USE SEEMS LIKELY, ASK THE FOLLOWING:			
You've told me that you've used (DRUG/ALCOHOL). Was there a period of at least six months when you were using a lot of different drugs at the same time? IF YES: Did it not matter which kind of drug you were taking as long as you could get high?	For at least six months, the [indiscriminate] use of at least three classes of psychoactive substances (not including nicotine and caffeine), but no single substance predominated. NOTE: IN CASES WITH BOTH PERIODS OF INDISCRIMINATE USE AND OTHER PERIODS OF USE OF SPECIFIC DRUGS, POLY DRUG SHOULD BE CODED IN ADDITION TO SPECIFIC DRUG COLUMNS.	1 2 3 → Use Poly drug column	45

? = inadequate information 1 = never or only once 2 = 10 or less in a month 3 = >10 times or dependence on prescribed drug

Now I'm going to ask you some specific questions about the time(s) you used (DRUGS CODED "2" OR "3") the most.

FOR EACH DRUG GROUP CODED "2" ON E.7 (I.E., ≤10 TIMES IN ONE MONTH), ASK ONLY THE TWO BOXED QUESTIONS, ITEM 4(A) AND ITEM (6).

FOR EACH DRUG GROUP CODED "3" ON E.7 (I.E., >10 TIMES IN ONE MONTH OR IF HOOKED ON A PRESCRIBED DRUG), ASK ALL OF THE QUESTIONS FOR EACH DRUG GROUP (INCLUDING THE TWO BOXED QUESTIONS).

Did you often find that when you started using (DRUG) you ended up taking much more of it than you were planning to?

IF NO: What about using it over a much longer period of time than you were planning to?

	SED./ HYPN./ ANX.	CANNABIS	STIMU-LANTS	OPIOID	COCAINE	HALL/ PCP	POLY	OTHER
(1) Substance often taken in larger amounts OR over a longer period than the person intended	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	(46)	(47)	(48)	(49)	(50)	(51)	(52)	(53)

Did you try to cut down or stop using (DRUG)?

IF YES: Did you ever actually stop taking (DRUG) altogether?

How many times did you try to cut down or stop altogether?

IF UNCLEAR: Did you want to stop or cut down?

IF YES: Is this something you kept worrying about?

	SED./ HYPN./ ANX.	CANNABIS	STIMU-LANTS	OPIOID	COCAINE	HALL/ PCP	POLY	OTHER
(2) Persistent desire OR one or more unsuccessful efforts to cut down or control substance use	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	(54)	(55)	(56)	(57)	(58)	(59)	(60)	(61)

Did you spend a lot of time taking (DRUG) or doing whatever you had to do to get it? Did it take you a long time to get back to normal? (How much time? As long as several hours?)	SED./ HYPN./ ANX.	CANNABIS	STIMU- LANTS	OPIOID	COCAINE	HALL/ PCP	POLY	OTHER
(3) A great deal of time spent in activities necessary to get the substance, taking the substance, or recovering from its effects	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	(16)	(17)	(18)	(19)	20)	(21)	(22)	(23)

Did you ever use (DRUG) in a situation in which it might have been dangerous? (Did you ever drive while you were really too stoned or high to be driving?)	SED./ HYPN./ ANX.	CANNABIS	STIMU- LANTS	OPIOID	COCAINE	HALL/ PCP	POLY	OTHER
(4)(a) Recurrent use when substance use is physically hazardous (e.g., drives when intoxicated)	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	(24)	25)	(26)	27)	28)	(29)	30)	(31)

Was there ever a time when you were often using (DRUG) or hung over from (DRUG) when you were doing something important, like being at school or work, or taking care of children? IF NO: What about missing something important, like staying away from school or work or missing an appointment because you were using (DRUG) or hung over?	SED./ HYPN./ ANX.	CANNABIS	STIMU- LANTS	OPIOID	COCAINE	HALL/ PCP	POLY	OTHER
(4)(b) Frequent intoxication or withdrawal symptoms when expected to fulfill major role obligations at work, school, or at home (e.g., doesn't go to work because hungover, goes to school or work high, intoxicated while taking care of children)	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	(32)	33)	(34)	35)	36)	(37)	38)	(39)

	SED./ HYPN./ ANX.	CANNABIS	STIMU- LANTS	OPIOID	COCAINE	HALL/ PCP	POLY	OTHER
(4) EITHER 4(a) OR 4(b) CODED "3"	3	3	3	3	3	3	3	3
	1	1	1	1	1	1	1	1
	(40)	(41)	(42)	(43)	(44)	(45)	(46)	(47)

Did you use (DRUG) so often that you started to use (DRUG) instead of working or spending time on hobbies or with your family or friends?

	SED./ HYPN./ ANX.	CANNABIS	STIMU- LANTS	OPIOID	COCAINE	HALL/ PCP	POLY	OTHER
(5) Important social, occupational, or recreational activities given up or reduced because of substance use	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	(48)	(49)	(50)	(51)	(52)	(53)	(54)	(55)

IF NOT ALREADY KNOWN: Did (DRUG) cause problems with other people, such as with family members or people at work?

IF NOT ALREADY KNOWN: Did (DRUG) cause psychological problems, like making you depressed?

IF NOT ALREADY KNOWN: Did (DRUG) ever cause physical problems or make a physical problem worse?

IF YES TO ANY OF THE ABOVE: Did you keep on using (DRUG) anyway?

	SED./ HYPN./ ANX.	CANNABIS	STIMU- LANTS	OPIOID	COCAINE	HALL/ PCP	POLY	OTHER
(6) Continued substance use despite knowledge of having a persistent or recurrent social, [significant] psychological, or [significant] physical problem that is caused or exacerbated by the use of the substance	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	(56)	(57)	(58)	(59)	(60)	(61)	(62)	(63)

Did you find that you needed to use a lot more (DRUG) in order to get high than you did when you first started using it?

IF YES: How much more?

IF NO: What about finding that when you used the same amount, it had much less effect than before?

	SED./ HYPN./ ANX.	CANNABIS	STIMU- LANTS	OPIOID	COCAINE	HALL/ PCP	POLY	OTHER
(7) Marked tolerance: need for markedly increased amounts of the substance (i.e., at least a 50% increase) in order to achieve intoxication or desired effect OR markedly diminished effect with continued use of the same amount	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	(64)	65)	(66)	67)	(68)	69)	70)	(71)

Duplicate

THE FOLLOWING TWO ITEMS MAY NOT APPLY TO CANNABIS AND HALLUCINOGENS/PCP

Have you ever had withdrawal symptoms, that is, felt sick when you cut down or stopped using (DRUG)?

IF YES: What symptoms did you have? REFER TO LIST OF WITHDRAWAL SYMPTOMS ON E.12.

	SED./ HYPN./ ANX.	CANNABIS	STIMU- LANTS	OPIOID	COCAINE	HALL/ PCP	POLY	OTHER
(8) Characteristic withdrawal symptoms	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	(16)	17)	(18)	19)	20)	21)	22)	23)

IF HAD WITHDRAWAL SXS: After not using (DRUG) for a few hours or more, did you often use it to keep yourself from getting sick with (WITHDRAWAL SXS)?

What about using (DRUG IN SAME GROUP) when you were feeling sick with (WITHDRAWAL SXS) so that you would feel better?

	SED./ HYPN./ ANX.	CANNABIS	STIMU- LANTS	OPIOID	COCAINE	HALL/ PCP	POLY	OTHER
(9) Substance often taken to relieve or avoid withdrawal symptoms	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1
	(24)	(25)	(26)	27)	28)	29)	30)	31)

AT LEAST ONE ITEM CODED "3" 1 3 32

Go to next module

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

LIST OF WITHDRAWAL SYMPTOMS (FROM DSM-III-R CRITERIA)

Listed below are the characteristic withdrawal symptoms for those classes of psychoactive substances for which a withdrawal syndrome has been identified. (NOTE: A specific withdrawal syndrome has not been identified for CANNABIS AND HALLUCINOGENS/PCP). Withdrawal symptoms may occur following the cessation of prolonged moderate or heavy use of a psychoactive substance, or a reduction in the amount used.

SEDATIVES, HYPNOTICS, AND ANXIOLYTICS:

At least two of the following:

(1) nausea or vomiting
(2) malaise or weakness
(3) autonomic hyperactivity (e.g., tachycardia, sweating)
(4) anxiety or irritability
(5) orthostatic hypotension
(6) coarse tremor of the hands, tongue, or eyelids
(7) marked insomnia
(8) grand mal seizures

STIMULANTS:

Dysphoric mood (depression, irritability, anxiety) and any of the following, persisting more than 24 hours after cessation of the substance use:

(1) fatigue
(2) insomnia or hypersomnia
(3) psychomotor agitation

OPIOIDS:

At least two of the following:

(1) craving for an opioid
(2) nausea or vomiting
(3) muscle aches
(4) lacrimation or rhinorrhea
(5) pupillary dilation, piloerection, or sweating
(6) diarrhea
(7) yawning
(8) fever
(9) insomnia

COCAINE:

Dysphoric mood (depression, irritability, anxiety) and any of the following, persisting more than 24 hours after cessation of the substance use:

(1) fatigue
(2) insomnia or hypersomnia
(3) psychomotor agitation

PSUD Duration

IF UNCLEAR: For how long a time were you having (SXS OF DRUG DEPENDENCE OR ABUSE)?	SED./ HYPN./ ANX.	CANNABIS	STIMU-LANTS	OPIOID	COCAINE	HALL/ PCP	POLY	OTHER
B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.	3	3	3	3	3	3	3	3
	1	1	1	1	1	1	1	1
	33)	34)	35)	36)	37)	38)	39)	40)

If all coded "1" go to next module

	SED./ HYPN./ ANX.	CANNABIS	STIMU-LANTS	OPIOID	COCAINE	HALL/ PCP	POLY	OTHER
Dependence (At least 3 out of the 9 Dependence items are coded "3" and criterion B is coded "3") NOTE: BE SURE NOT TO COUNT ITEMS (4)(a) AND (4)(b) AS SEPARATE ITEMS	3	3	3	3	3	3	3	3
Abuse (If below threshold for Dependence, either item (4)(a) or item (6) is coded "3." and criterion B is coded "3")	2	2	2	2	2	2	(NO ABUSE SYNDROME)	2
Neither Dependence nor Abuse	1	1	1	1	1	1	1	1
	41)	42)	43)	44)	45)	46)	47)	48)

If all coded "1" go to next module

Chronology

Have you had problems with (DRUG CODED "2" OR "3") in past month?	SED./ HYPN./ ANX.	CANNABIS	STIMU-LANTS	OPIOID	COCAINE	HALL/ PCP	POLY	OTHER
Symptoms of abuse or dependence in the past month	3	3	3	3	3	3	3	3
	1	1	1	1	1	1	1	1
	49)	50)	51)	52)	53)	54)	55)	56)

IF NO DEPENDENCE (i.e., no drugs coded "3" above), GO TO NEXT MODULE.

	SED./ HYPN./ ANX.	CANNABIS	STIMU- LANTS	OPIOID	COCAINE	HALL/ PCP	POLY	OTHER
USE SCALE BELOW TO RATE SEVERITY OF DEPENDENCE FOR WORST WEEK OF PAST MONTH (Additional questions about the effect of the substance on social and occupational functioning may be necessary.)	1	1	1	1	1	1	1	1
	2	2	2	2	2	2	2	2
	3	3	3	3	3	3	3	3
	4	4	4	4	4	4	4	4
	5	5	5	5	5	5	5	5
	(57)	(58)	(59)	(60)	(61)	(62)	(63)	(64)

1 Mild: Few, if any, symptoms in excess of those required to make the diagnosis, and the symptoms result in no more than mild impairment in occupational functioning, or in usual social activities or relationships with others.

2 Moderate: Symptoms or functional impairment between "mild" and "severe."

3 Severe: Many symptoms in excess of those required to make the diagnosis, and the symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.

4 In Partial Remission: During the past six months, some use of the substance and some symptoms of dependence.

5 In Full Remission: During the past six months, either no use of the substance, or use of the substance and no symptoms of dependence.

IF ALL DRUG DEPENDENCE IN PARTIAL OR FULL REMISSION (i.e., all coded "4" or "5"):

Number of months prior to interview when last had some symptoms of dependence ___ ___ ___ (65-67)

NON-ALCOHOL PSYCHOACTIVE SUBSTANCE DEPENDENCE PAST FIVE YEARS

During the past five years, how much of the time have you had (SXS OF DEPENDENCE ON ANY DRUG)?

Approximate percentage of time during past five years that any symptoms of Non-alcohol Dependence were present

Would you say . . . [CODE DESCRIPTIONS]?

1 Not at all (0%) 68

2 Rarely (e.g., 5–10%)

3 A significant minority of the time (e.g., 20–30%)

4 About half the time

5 A significant majority of the time (e.g., 70–80%)

6 Almost all the time (e.g., 90–100%)

9 Unknown

How old were you when you first had (LIST OF NON-ALCOHOL SUBSTANCE DEPENDENCE SXS CODED "3")?

Age at onset of Non-alcohol Substance Dependence (CODE 99 IF UNKNOWN) — — 69-70

CHECK HERE IF EVER BECAME DEPENDENT ON A PRESCRIBED DRUG ____ 71

SPECIFY DRUG: _____

F. ANXIETY DISORDERS

PANIC DISORDER

	PANIC DISORDER CRITERIA					
Have you ever had a panic attack, when you *suddenly* felt frightened, anxious or extremely uncomfortable? IF YES: Tell me about it. When does that happen? (Have you ever had one that just seemed to come on out of the blue?) IF PANIC ATTACKS IN EXPECTED SITUATIONS: Did you ever have one of these attacks when you weren't in (EXPECTED SITUATION)?	A. At some time during the disturbance, one or more panic attacks (discrete periods of intense fear or discomfort) have occurred that were (1) unexpected, i.e., did not occur immediately before or on exposure to a situation that almost always causes anxiety, and (2) not triggered by situations in which the person was the focus of others' attention.	?	1	2	3	
			Go to "AWOPD," F.2			
Have you ever had four attacks like that in a four-week period? IF NO: Did you worry a lot about having another one? (How long did you worry?)	B. Either four attacks, as defined in criterion A, have occurred within a four-week period, or one or more attacks have been followed by a period of at least a month of persistent fear of having another attack.	?	1	2	3	
			Go to "AWOPD," F.2			
When was the last bad one (EXPECTED OR UNEXPECTED)? Now I am going to ask you about that attack. What was the first thing you noticed? Then what? During that attack . . .	C. At least four of the following symptoms developed during at least one of the attacks:					
. . were you short of breath? (Have trouble catching your breath?)	(1) shortness of breath (dyspnea) or smothering sensations	?	1	2	3	
. . did you feel dizzy, unsteady, or like you might faint?	(2) dizziness, unsteady feelings, or faintness	?	1	2	3	
. . did your heart race, pound or skip?	(3) palpitations or accelerated heart rate (tachycardia)	?	1	2	3	
. . did you tremble or shake?	(4) trembling or shaking	?	1	2	3	
. . did you sweat?	(5) sweating	?	1	2	3	
. . did you feel as if you were choking?	(6) choking	?	1	2	3	
. . did you have nausea or upset stomach or the feeling that you were going to have diarrhea?	(7) nausea or abdominal distress	?	1	2	3	
. . did things around you seem unreal or did you feel detached from things around you or detached from part of your body?	(8) depersonalization or derealization	?	1	2	3	

During that attack . . .

. . did you have tingling or numbness in parts of your body?	(9) numbness or tingling sensations (paresthesias)	? 1 2 3		26
. . did you have flushes (hot flashes) or chills?	(10) flushes (hot flashes) or chills	? 1 2 3		27
. . did you have chest pain or pressure?	(11) chest pain or discomfort	? 1 2 3		28
. . were you afraid that you might die?	(12) fear of dying	? 1 2 3		29
. . were you afraid you were going crazy or might lose control?	(13) fear of going crazy or of doing something uncontrolled	? 1 2 3		30
	AT LEAST FOUR "C" SXS ARE CODED "3"	1	3	31
	NOTE: ATTACKS INVOLVING FOUR OR MORE SYMPTOMS ARE PANIC ATTACKS; ATTACKS INVOLVING FEWER THAN FOUR SYMPTOMS ARE LIMITED SYMPTOM ATTACKS (SEE **"Agoraphobia Without History of Panic Disorder,"** F.6).	Go to "AWOPD," F.6		
When you have bad attacks, how long does it take from when it begins to when you have most of the symptoms? (Is it often less than ten minutes?)	D. During at least some of the attacks, at least four of the "C" symptoms developed suddenly and increased in intensity within ten minutes of the beginning of the first "C" symptom noticed in the attack.	? 1 2 3		32
		Go to "AWOPD," F.6		
Just before you began having panic attacks, were you taking any drugs, stimulants or medicines?	E. It cannot be established that an organic factor initiated and maintained the disturbance.	? 1	3	33
(How much coffee, tea, or cola do you drink a day?)	IF ORGANIC FACTOR, DESCRIBE:	R/O Organic Anxiety Syndrome. Go to "AWOPD," F.6	No organic etiology. Continue	
Were you physically ill? (What did the doctor say?)	Established organic factors include: hyper- and hypothyroidism, pheochromocytoma, fasting hypoglycemia, hypercortisolism, stimulant intoxication (e.g., caffeine, cocaine, amphetamine), cannabis and hallucinogen intoxication, withdrawal states.			
IF ANY OF THESE ORGANIC FACTORS WERE PRESENT JUST BEFORE THE PANIC ATTACKS: Did you ever have these attacks when you weren't (taking any drugs or medicines/using a lot of caffeine/physically ill)?	NOTE: CODE "3" IF SUBSTANCE USE OR PHYSICAL ILLNESS WAS NOT ETIOLOGIC TO PANIC ATTACKS.			
	NOTE: Mitral valve prolapse may be an associated condition, but does not preclude a diagnosis of Panic Disorder			
	PANIC DISORDER CRITERIA A, B, C, D AND E ARE CODED "3"	1	3	34
		Go to "AWOPD," F.6	Panic Disorder	

?=inadequate information 1=absent or false 2=subthreshold 3=threshold or true

PANIC DISORDER SUBTYPE

IF NOT OBVIOUS FROM OVERVIEW: Have there been situations or places that you avoided because you were afraid that you might have an attack?

(Tell me all the things you avoided, or could do only when someone was with you, or by forcing yourself.)

IF CANNOT GIVE SPECIFICS: What about. . .

. . being at home alone?

. . shopping alone in a big store?

. . walking far from home alone?

. . crossing busy or wide streets alone?

. . being alone in a crowded place—like a movie theatre, a church, or a restaurant?

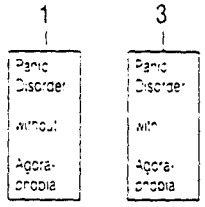
. . using public transportation—like a bus, train, or subway—or driving a car?

IF NOT OBVIOUS: What effect did avoiding (AGORAPHOBIC SITUATIONS) have on your life?

WITH AGORAPHOBIA

Fear of being in places or situations from which escape might be difficult (or embarrassing), or in which help might not be available in the event of a panic attack. (Include cases in which persistent avoidance behavior originated during an active phase of Panic Disorder, even if the person does not attribute the avoidance behavior to fear of having a panic attack.)

As a result of this fear, the person either restricts travel, needs a companion when away from home, or else endures agoraphobic situations despite intense anxiety. Common agoraphobic situations include being outside the home alone, being in a crowd or standing in a line, being on a bridge, traveling in a bus, train, or car.



"Chronology of Panic Disorder"

IF UNCLEAR: During the past month, how many panic attacks have you had?	Has met symptomatic criteria for Panic Disorder during past month, i.e., at least 4 panic attacks OR persistent fear of having a panic attack (or agoraphobic avoidance)	? 1 3	36
When did you last have (ANY SX OF PANIC DISORDER)?	Number of months prior to interview when last had a symptom of Panic Disorder	— — —	37-39

SEVERITY OF PANIC ATTACKS:

1 Mild: During the past month, either all attacks have been limited symptom attacks (i.e., fewer than four sxs), or there has been no more than one panic attack.

2 Moderate: During the past month, attacks have been intermediate between "mild" and "severe."

3 Severe: During the past month, there have been at least eight panic attacks.

4 In Partial Remission: Intermediate between "in full remission" and "mild."

5 In Full Remission: During the past six months, no panic or limited symptom attacks.

40

SEVERITY OF AGORAPHOBIC AVOIDANCE:

1 Never had agoraphobic avoidance.

2 Mild: During past month, some avoidance (or endurance with distress), relatively normal life style, e.g., travels unaccompanied when necessary, such as to work or to shop; otherwise avoids traveling alone.

3 Moderate: During past month, avoidance results in constricted lifestyle, e.g., able to leave house alone but not able to go more than a few miles unaccompanied.

4 Severe: During past month, avoidance results in being nearly or completely housebound or unable to leave house unaccompanied.

5 In Partial Remission: No current agoraphobic avoidance, but some agoraphobic avoidance during the past six months.

6 In Full Remission: No current agoraphobic avoidance and none during the past six months.

41

Past Five Years

During the past five years, how much of the time have you been bothered by (PANIC ATTACKS, PERSISTENT FEAR OF HAVING AN ATTACK, OR AGORAPHOBIC AVOIDANCE)?

Approximate percentage of time during past five years that any symptoms of Panic Disorder were present

Would you say . . . [CODE DESCRIPTIONS]?

1 Not at all (0%)

2 Rarely (e.g., 5–10%)

3 A significant minority of the time (e.g., 20–30%)

4 About half the time

5 A significant majority of the time (e.g., 70–80%)

6 Almost all the time (e.g., 90–100%)

9 Unknown

How old were you when you first started having a lot of panic attacks (or worried a great deal about having one)?

Age at onset of Panic Disorder (at least four attacks over a four-week period or one or more attacks followed by persistent fear of having another attack) (CODE 99 IF UNKNOWN)

— —

Agoraphobia Without History of Panic Disorder (AWOPD)

AGORAPHOBIA WITHOUT HISTORY OF PANIC DISORDER (AWOPD) CRITERIA

IF: EVER MET CRITERIA FOR PANIC DISORDER **OR** CURRENT PSYCHOTIC DISORDER **OR** IN RESIDUAL PHASE OF SCHIZOPHRENIA. CHECK HERE ____ AND SKIP TO ***Social Phobia,* F.8.**

Were you ever afraid of going out of the house alone, being in crowds, standing in a line, or traveling on buses or trains?

What were you afraid could happen?

A. Fear of being in places or situations from which escape might be difficult (or embarrassing), or in which help might not be available, *in the event of suddenly developing a symptom(s) that could be incapacitating or extremely embarrassing.* Examples include dizziness or falling, depersonalization or derealization, loss of bladder or bowel control, vomiting or cardiac distress.

? 1 2 3 45

Go to "Social Phobia," F.8.

Tell me all the things you avoided (or could only do by forcing yourself).

(How often did you go outside of your house alone?)

(Did you often need a companion?)

(What effect did avoiding these situations or places have on your life?)

As a result of this fear, the person either restricts travel or needs a companion when away from home, or else endures agoraphobic situations despite intense anxiety. Common agoraphobic situations include being outside the home alone, being in a crowd or standing in a line, being on a bridge, and traveling in a bus, train, or car.

IF FEAR OF INCAPACITATION IS RELATED TO A SPECIFIC SYMPTOM, CHECK BELOW:

____ having a limited symptom attack (a panic attack with less than four symptoms) 46

____ becoming dizzy or falling 47

____ depersonalization or derealization 48

____ loss of bladder or bowel control 49

____ vomiting 50

____ fear of cardiac distress 51

____ other (Specify: _____) 52

[B. The restriction in activity is not due to a realistic concern about the consequences of a preexisting Axis III disorder, e.g., appropriate restriction in activity following a myocardial infarction, AND does not occur exclusively during the course of Posttraumatic Stress Disorder.] 53

? 1 2 3

Go to "Social Phobia," F.8

Agoraphobia without history of Panic Disorder

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

CHRONOLOGY

IF UNCLEAR: During the past month, have you avoided (PHOBIC SITUATIONS)?	Has met criteria for Agoraphobia without History of Panic Disorder during past month	?	1	3
When did you last avoid (PHOBIC SITUATIONS)?	Number of months prior to interview when last had a symptom of Agoraphobia without History of Panic Disorder	— — —		

"Past Five Years"

During the past five years, how much of the time have you avoided these situations because you were afraid?

Approximate percentage of time during past five years that any symptoms of Agoraphobia without History of Panic Disorder were present

Would you say . . . [CODE DESCRIPTIONS]?

1 Not at all (0%)

2 Rarely (e.g., 5–10%)

3 A significant minority of the time (e.g., 20–30%)

4 About half the time

5 A significant majority of the time (e.g., 70–80%)

6 Almost all the time (e.g., 90–100%)

9 Unknown

How old were you when you first had this problem?

Age at onset of Agoraphobia without History of Panic Disorder (CODE 99 IF UNKNOWN) — —

"Social Phobia" SOCIAL PHOBIA CRITERIA

IF: CURRENT PSYCHOTIC DISORDER **OR** IN RESIDUAL PHASE OF SCHIZOPHRENIA, CHECK HERE ____ AND SKIP TO **"Obsessive Compulsive Disorder,"** F.12.

Is there anything that you were ever afraid to do or felt uncomfortable doing in front of other people, like speaking, eating, or writing?

Anything else?

What were you afraid would happen when _____?

IF PUBLIC SPEAKING ONLY: (Do you think that you are more uncomfortable than most people are in that situation?)

A. A persistent fear of one or more situations (the phobic situations) in which the person is exposed to possible scrutiny by others and fears that he or she may do something or act in a way that will be humiliating or embarrassing. Examples include: being unable to continue talking while speaking in public, choking on food when eating in front of others, being unable to urinate in a public lavatory, hand-trembling when writing in the presence of others, and being afraid of saying foolish things or not being able to answer questions in social situations.

? 1 2 3 61

Go to "Simple Phobia," F.10

PHOBIC SITUATION(S) Check:

____ public speaking 62
____ eating in front of others 63
____ writing in front of others 64
____ generalized (most social situations) 65
____ other (Specify: _____) 66

IF NOT ALREADY CLEAR: RETURN TO THIS ITEM AFTER COMPLETING INTERVIEW.

B. If an Axis III or another Axis I disorder is present, the fear in "A" is unrelated to it, e.g., the fear is not of having a panic attack (Panic Disorder), stuttering (Stuttering), trembling (Parkinson's Disease), exhibiting abnormal eating behavior (Anorexia Nervosa or Bulimia Nervosa).

? 1 2 3 67

Go to "Simple Phobia," F.10

? 1 2 3 duplicate 9 / 12 13 14 15

IF UNCLEAR WHETHER FEAR WAS CLINICALLY SIGNIFICANT: How much did _____interfere with your life?

IF DOES NOT INTERFERE WITH LIFE: How much has the fact that you have this fear bothered you?

C. The avoidant behavior interferes with occupational functioning or with usual social activities or relationships with others, or there is marked distress about having the fear.

? 1 2 3 68

Go to "Simple Phobia," F.10

Did you always feel anxious when you (CONFRONTED PHOBIC STIMULUS)?

D. During some phase of the disturbance, exposure to the specific phobic stimulus (or stimuli) almost invariably provokes an immediate anxiety response.

? 1 2 3 69

Go to "Simple Phobia," F.10

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

IF NOT OBVIOUS: Did you go out of your way to avoid _____?

IF NO: How hard is it for you to _____?

E. The phobic situation(s) is avoided, or endured with intense anxiety.

? 1 2 3 18

Go to "Simple Phobia," F:10

Did you think that you were more afraid of (PHOBIC ACTIVITY) than you should have been (or than made sense)?

F. The person recognizes that his or her fear is excessive or unreasonable.

? 1 2 3 19

Go to "Simple Phobia," F:10

SOCIAL PHOBIA CRITERIA A, B, C, D, E, AND F ARE CODED "3"

1 3 20

Go to "Simple Phobia," F:10

Social Phobia

CHRONOLOGY

IF UNCLEAR: During the past month, have you been bothered by (SOCIAL PHOBIA SITUATION)?

Has met criteria for Social Phobia during past month

? 1 3 21

When were you last bothered by (SOCIAL PHOBIA SITUATION)?

Number of months prior to interview when last had a symptom of Social Phobia

— — — 22-24

"Past Five Years"

During the past five years, how much of the time have (SX OF SOCIAL PHOBIA) either interfered with your life or bothered you a lot?

Would you say . . . [CODE DESCRIPTIONS]?

Approximate percentage of time during past five years that symptoms of Social Phobia either interfered with functioning or caused marked distress

1 Not at all (0%) 25

2 Rarely (e.g., 5–10%)

3 A significant minority of the time (e.g., 20–30%)

4 About half the time

5 A significant majority of the time (e.g., 70–80%)

6 Almost all the time (e.g., 90–100%)

9 Unknown

How old were you when you were first bothered by (SOCIAL PHOBIA SITUATION)?

Age at onset of Social Phobia (CODE 99 IF UNKNOWN)

— — 26-27

Simple Phobia

SIMPLE PHOBIA CRITERIA

Are there any other things that you have been especially afraid of, like flying, heights, seeing blood, closed places, or certain kinds of animals or insects?

What are you afraid could happen when _____?

A. A persistent fear of a circumscribed stimulus (object or situation), other than of having a panic attack (as in Panic Disorder) or of humiliation or embarrassment in certain social situations (as in Social Phobia). NOTE: DO NOT INCLUDE FEARS THAT ARE PART OF PANIC DISORDER WITH AGORAPHOBIA OR AGORAPHOBIA WITHOUT HISTORY OF PANIC DISORDER.

? 1 2 3 28

Go to "Obsessive Compulsive Disorder," C "2

PHOBIC OBJECT(S) OR SITUATION(S). Check:

____ animals 29
____ heights 30
____ closed spaces 31
____ blood/injury 32
____ other: _____ 33

IF UNCLEAR WHETHER FEAR WAS CLINICALLY SIGNIFICANT: How much did _____ interfere with your life?

(Is there anything you've avoided because of being afraid of _____?)

IF DOES NOT INTERFERE WITH LIFE: How much has the fact that you were afraid of _____ bothered you?

B. The fear of the avoidant behavior significantly interferes with the person's normal routine or with usual social activities or relationships with others, or there is marked distress about having the fear.

? 1 2 3 34

Go to "Obsessive Compulsive Disorder," C "2

Did you always feel anxious when you (CONFRONTED PHOBIC STIMULUS)?

C. During some phase of the disturbance, exposure to the specific phobic stimulus (or stimuli) almost invariably provokes an immediate anxiety response.

? 1 2 3 35

Go to "Obsessive Compulsive Disorder," C "2

Did you go out of your way to avoid _____?

(Are there things you didn't do because of this fear that you would otherwise have done?)

IF NO: How hard (is/was) it for you to _____?

D. The object or situation is avoided, or endured with intense anxiety.

? 1 2 3 36

Go to "Obsessive Compulsive Disorder," C "2

Did you think that you were more afraid of _____ than you should have been (or than made sense)?

E. The person recognizes that his or her fear is excessive or unreasonable.

? 1 2 3 37

Go to "Obsessive Compulsive Disorder," C "2

IF NOT ALREADY CLEAR: RETURN TO THIS ITEM AFTER COMPLETING SECTION ON OBSESSIVE COMPULSIVE DISORDER.

F. The phobic stimulus is unrelated to the content of the obsessions of Obsessive Compulsive Disorder or to the trauma of Posttraumatic Stress Disorder.

? 1 2 3 38

Go to "Obsessive Compulsive Disorder," F.12

SIMPLE PHOBIA CRITERIA A, B, C, D, E, AND F ARE CODED "3"

? 1 3 39

Go to "Obsessive Compulsive Disorder," F.12

Simple Phobia

CHRONOLOGY

IF UNCLEAR: During the past month, have you been bothered by (SIMPLE PHOBIA)?

Has met criteria for Simple Phobia during past month

? 1 3 40

When were you last bothered by (SIMPLE PHOBIA)?

Number of months prior to interview when last had a symptom of Simple Phobia

— — — 41-43

Past Five Years

During the past five years, how much of the time has (SX OF SIMPLE PHOBIA) interfered with your life or bothered you a lot?

Approximate percentage of time during past five years that symptoms of Simple Phobia either interfered with functioning or caused marked distress

Would you say . . . [CODE DESCRIPTIONS]?

1 Not at all (0%) 44

2 Rarely (e.g., 5–10%)

3 A significant minority of the time (e.g., 20–30%)

4 About half the time

5 A significant majority of the time (e.g., 70–80%)

6 Almost all the time (e.g., 90–100%)

9 Unknown

How old were you when you were first bothered by (SXS OF SIMPLE PHOBIA)?

Age at onset of Simple Phobia

— — 45-46

•Obsessive Compulsive Disorder•

OBSESSIVE COMPULSIVE DISORDER CRITERIA

A. Either obsessions or compulsions:

Obsessions: (1), (2), (3), and (4):

Now I would like to ask you if you have ever been bothered by thoughts that didn't make any sense and kept coming back to you even when you tried not to have them? (What were they?)

(What about awful thoughts, like actually hurting someone even though you didn't want to, or being contaminated by germs or dirt?)

(1) Recurrent and persistent ideas, thoughts, impulses, or images that are experienced, at least initially, as intrusive and senseless, e.g., a parent having repeated impulses to hurt a loved child, a religious person having recurrent blasphemous thoughts

? 1 2 3 47

NOTE: DO NOT INCLUDE BROODING ABOUT PROBLEMS (SUCH AS HAVING A PANIC ATTACK) OR ANXIOUS RUMINATIONS ABOUT REALISTIC DANGERS.

When you had these thoughts, did you try hard to get them out of your head? (What would you try to do?)

(2) The person attempts to ignore or suppress such thoughts or to neutralize them with some other thought or action

? 1 2 3 48

IF UNCLEAR: Where did you think these thoughts were coming from?

(3) The person recognizes that the obsessions are the product of his or her own mind, not imposed from without (as in thought insertion)

? 1 2 3 49

(4) If another Axis I disorder is present, the content of the obsession is unrelated to it, i.e., the ideas, thoughts, impulses, or images are not about food in the presence of an Eating Disorder, about drugs in the presence of a Psychoactive Substance Use Disorder, or include guilty thoughts in the presence of a Major Depression

? 1 2 3 50

Obsessions

DESCRIBE:

(continue on next page)

Was there ever anything that you had to do over and over again and couldn't resist doing, like washing your hands again and again, or checking something several times to make sure you'd done it right?

IF YES: What did you have to do? (What were you afraid would happen if you didn't do it?) (How many times did you have to _____? How much time did you spend each day _____?)

IF UNCLEAR: Do you think that you (DO COMPULSIVE BEHAVIOR) more than you should? (Do you think [COMPULSION] makes sense?)

Compulsions: (1), (2), and (3):

(1) Repetitive, purposeful, and intentional behaviors that are performed in response to an obsession, or according to certain rules, or in a stereotyped fashion — ? 1 2 3

(2) The behavior is designed to neutralize or prevent discomfort or some dreaded event or situation; however, either the activity is not connected in a realistic way with what it is designed to neutralize or prevent, or it is clearly excessive — ? 1 2 3

(3) The person recognizes that the behavior is excessive or unreasonable (this may no longer be true for people whose obsessions have evolved into overvalued ideas) — ? 1 2 3

Compulsions

DESCRIBE:

IF NEITHER OBSESSIONS NOR COMPULSIONS, CHECK HERE AND GO TO **"Generalized Anxiety Disorder,"** F.15 _____.

What effect did this (OBSESSION OR COMPULSION) have on your life? (Did _____bother you a lot?)

(How much time do you spend [OBSESSION OR COMPULSION])?

(Did anyone in your family, or your friends, have to go out of their way because of your [OBSESSION OR COMPULSION]?)

B. The obsessions or compulsions cause marked distress, are time-consuming (take more than an hour a day), or significantly interfere with the person's normal routine, occupational functioning, or usual social activities or relationships with others. — ? 1 2 3

Go to "GAD," F.15

DESCRIBE:

OBSESSIVE COMPULSIVE DISORDER CRITERIA A AND B ARE CODED "3" — 1 3

Go to "GAD," F.15

Obsessive Compulsive Disorder

CHRONOLOGY

IF UNCLEAR: During the past month, did the (OBSESSIONS OR COMPULSIONS) have any effect on your life or bother you a lot?	Has met criteria for Obsessive Compulsive Disorder during past month (criteria A and B)	?	1	3	57
When were you last bothered by (ANY OBSESSIONS OR COMPULSIONS)?	Number of months prior to interview when last had symptoms of Obsessive Compulsive Disorder		— — —		58-60

Past Five Years

During the past five years, how much of the time have (ANY OBSESSIONS OR COMPULSIONS) had an effect on your life or bothered you a lot?	Approximate percentage of time during past five years that any symptoms of Obsessive Compulsive Disorder were present		
Would you say . . . [CODE DESCRIPTIONS]?	1 Not at all (0%)		61
	2 Rarely (e.g., 5–10%)		
	3 A significant minority of the time (e.g., 20–30%)		
	4 About half the time		
	5 A significant majority of the time (e.g., 70–80%)		
	6 Almost all the time (e.g., 90–100%)		
	9 Unknown		
How old were you when the (OBSESSIONS OR COMPULSIONS) first had any effect on your life or bothered you a lot?	Age at onset of Obsessive Compulsive Disorder (criteria A and B) (CODE 99 IF UNKNOWN)	— —			62-63

***Generalized Anxiety Disorder* (CURRENT ONLY)**

GENERALIZED ANXIETY DISORDER CRITERIA

IF: CURRENT MOOD OR PSYCHOTIC DISORDER **OR** IN RESIDUAL PHASE OF SCHIZOPHRENIA, CHECK HERE ____ AND SKIP TO NEXT MODULE.

In the last six months, have you been particularly nervous or anxious?

Do you worry a lot about terrible things that might happen?

IF YES: What do you worry about? (How realistic is that?)

During the last six months, would you say that you have been worrying most of the time (more days than not)?

A. Unrealistic or excessive anxiety and worry (apprehensive expectation) about two or more life circumstances, e.g., worry about possible misfortune to child (who is in no danger) and worry about finances (for no good reason) *for a period of six months or longer* during which the person has been bothered *more days than not* by these concerns. In children and adolescents, this may take the form of anxiety and worry about academic, athletic, and social performance.

? 1 2 3

Go to next module

CODE BASED ON PREVIOUS INFORMATION. REVISE AT END OF INTERVIEW IF NECESSARY.

B. If another Axis I disorder is present, the focus of the worry in "A" is unrelated to it, e.g., the anxiety or worry is not about having a panic attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive Compulsive Disorder), or gaining weight (as in Anorexia Nervosa).

? 1 2 3

Go to next module

Now I am going to ask you some questions about other symptoms that often go along with being nervous.

C. At least six of the following eighteen symptoms are often present when anxious (DO NOT INCLUDE SXS PRESENT ONLY DURING PANIC ATTACKS):

Thinking about those periods in the past six months when you're feeling nervous or anxious . . .

Motor tension

. . do you often tremble, twitch, or feel shaky?

(1) trembling, twitching, or feeling shaky

? 1 2 3

. . do your muscles often feel tense, sore, or achy?

(2) muscle tension, aches, or soreness

? 1 2 3

. . do you often feel physically restless—can't sit still?

(3) restlessness

? 1 2 3

. . do you often tire easily?

(4) easy fatigability

? 1 2 3

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

At those times when you're feeling nervous or anxious . . .						
	Autonomic hyperactivity					
. . do you often feel short of breath? (have trouble catching your breath?)	(5) shortness of breath or smothering sensations	?	1	2	3	20
. . does your heart often pound or race?	(6) palpitations or accelerated heart rate (tachycardia)	?	1	2	3	21
. . do you often sweat a lot? Are your hands often cold or clammy?	(7) sweating or cold, clammy hands	?	1	2	3	22
. . does your mouth often feel dry?	(8) dry mouth	?	1	2	3	23
. . do you often feel dizzy or lightheaded?	(9) dizziness or lightheadedness	?	1	2	3	24
. . is your stomach often upset, or do you have nausea or diarrhea?	(10) nausea, diarrhea or other abdominal distress	?	1	2	3	25
. . do you often have flushes (hot flashes) or chills?	(11) flushes (hot flashes) or chills	?	1	2	3	26
. . do you urinate more often than usual?	(12) frequent urination	?	1	2	3	27
. . do you often have trouble swallowing, or get a lump in your throat?	(13) trouble swallowing or "lump in throat"	?	1	2	3	28
At those times when you're feeling nervous or anxious . . .						
	Vigilance and scanning					
. . do you often feel keyed up or on edge?	(14) feeling keyed up or on edge	?	1	2	3	29
. . do sudden noises often startle you?	(15) exaggerated startle response	?	1	2	3	30
. . do you have trouble concentrating or does your mind go blank?	(16) difficulty concentrating or "mind going blank" because of anxiety	?	1	2	3	31
. . do you often have trouble falling or staying asleep?	(17) trouble falling or staying asleep	?	1	2	3	32
. . are you often irritable?	(18) irritability	?	1	2	3	33
	AT LEAST SIX "C" SXS ARE CODED "3"		1		3	34
			Go to next module			
When did all this begin?	Age at onset of Generalized Anxiety Syndrome (criteria A, B, and C) (CODE 99 IF UNKNOWN)				— —	35-36

? = inadequate information 1 = absent or false 2 = subthreshold 3 = threshold or true

CODE BASED ON PREVIOUS INFORMATION.

Just before this began, were you physically ill? (What did the doctor say?)

Were you taking any medicines or street drugs? (Any change in the amount you were taking?)

(How much coffee, tea, or cola do you drink a day?)

IF YES TO ANY OF THESE QUESTIONS, DETERMINE IF THE PERIOD OF ANXIETY WAS INITIATED AND MAINTAINED BY AN ORGANIC FACTOR

D. The disturbance does not occur only during the course of a Mood Disorder or a psychotic disorder.

? 1 3 37

Go to next module

E. It cannot be established that an organic factor initiated and maintained the disturbance.

IF ORGANIC FACTOR, DESCRIBE:

Established organic factors include: hyper- and hypothyroidism, pheochromocytoma, fasting hypoglycemia, hypercortisolism, stimulant intoxication (e.g., caffeine, cocaine, amphetamine)

? 1 3 38

R/O Organic Anxiety Syndrome

Go to next module

No organic etiology

Continue

GENERALIZED ANXIETY CRITIERA A, B, C, D, AND E ARE CODED "3"

1 3 39

Go to next module

Generalized Anxiety Disorder

Sedatives-hyponotics-anxiolytics: ("downers")

Quaalude ("ludes")	barbiturates
Seconal ("reds")	Miltown
Valium	Ativan
Xanax	Dalmane
Librium	Halcion

Cannabis:

marijuana	"grass"
hashish ("hash")	"weed"
THC	"reefer"
"pot"	

Stimulants: ("uppers")

Amphetamine	dexadrine
"speed"	Ritalin
crystal meth	diet pills

Opioids:

heroin	codeine
morphine	Percodan
opium	Demerol
Methadone	Dilaudid
Darvon	

Cocaine:

snorting	crack
IV	"speedball"
freebase	

Hallucinogens: ("psychedelics")

LSD ("acid")	psilocybin
mescaline	STP
peyote	mushrooms
PCP ("angel dust," "peace pill)	

Other:

Steroids	Extasy
"glue"	MDA
ethyl chloride	MDM
nitrous oxide ("laughing gas")	nonprescription sleep or diet pills
amyl or butyl nitrate ("poppers")	

APPENDIX (c)

T.C.I.

Read each statement carefully, but don't spend too much time deciding on the answer.

Please answer every statement by circling either "T" or "F" after each question, even if you are not completely sure of the answer.

Remember there are no right or wrong answers - just describe your own personal opinions and feelings.

		TRUE	FALSE
1.	I often try new things just for fun and thrills, even if most people think it is a waste of time	T	F
2.	I usually am confident that everything will go well even in situations that worry most people	T	F
3.	I am often moved deeply by a fine speech or poetry	T	F
4.	I often feel that I am the victim of circumstances	T	F
5.	I can usually accept other people as they are, even when they are very different from me	T	F
6.	I believe that miracles happen	T	F
7.	I enjoy getting revenge on people who hurt me	T	F
8.	Often when I am concentrating on something, I lose awareness of the passage of time	T	F
9.	Often I feel that my life has little purpose or meaning	T	F
10.	I like to help find a solution to problems so that everyone comes out ahead	T	F
11.	I could probably accomplish more than I do, but I don't see the point in pushing myself harder than is necessary to get by	T	F
12.	I often feel tense and worried in unfamiliar situations, even when others feel there is little to worry about	T	F
13.	I often do things based on how I feel at the moment without thinking about how they were done in the past	T	F
14.	I usually do things my own way, rather than giving in to the wishes of other people	T	F
15.	I often feel so connected to the people around me that it is like there is no separation between us	T	F
16.	I generally don't like people who have different ideas from me	T	F
17.	In most situations my natural responses are based on good habits that I have developed	T	F
18.	I would do almost anything legal in order to become rich and famous, even if I would lose the trust of many old friends	T	F
19.	I am much more reserved and controlled than most people	T	F
20.	I often have to stop what I am doing because I start worrying about what might go wrong	T	F
21.	I like to discuss my experiences and feelings openly with friends instead of keeping them to myself	T	F
22.	I have less energy and get tired more quickly than most people	T	F
23.	I am often called "absent-minded" because I get so wrapped up in what I am doing that I lose track of everything else	T	F

24. I seldom feel free to choose what I want to do ..... T F

25. I often consider another person's feelings as much as my own ..... T F

26. Most of the time I would prefer to do something a little risky (like riding in a fast automobile over steep hills and sharp turns) rather than having to stay quiet and inactive for a few hours ..... T F

27. I often avoid meeting strangers because I lack confidence with people I do not know ..... T F

28. I like to please other people as much as I can ..... T F

29. I like old "tried and true" ways of doing things much better than trying "new and improved" ways ..... T F

30. Usually I am not able to do things according to their priority of importance to me because of lack of time ..... T F

31. I often do things to help protect animals and plants from extinction ..... T F

32. I often wish that I was smarter than everyone else ..... T F

33. It gives me pleasure to see my enemies suffer ..... T F

34. I like to be very organized and set up rules for people whenever I can ..... T F

35. It is difficult for me to keep the same interests for a long time because my attention often shifts to something else ..... T F

36. Repeated practice has given me good habits that are stronger than most momentary impulses or persuasion ..... T F

37. I am usually so determined that I continue to work long after other people have given up ..... T F

38. I am fascinated by the many things in life that cannot be scientifically explained ..... T F

39. I have many bad habits that I wish I could break ..... T F

40. I often wait for someone else to provide a solution to my problems ..... T F

41. I often spend money until I run out of cash or get into debt from using too much credit ..... T F

42. I think I will have very good luck in the future ..... T F

43. I recover more slowly than most people from minor illnesses or stress ..... T F

44. It wouldn't bother me to be alone all the time ..... T F

45. Often I have unexpected flashes of insight or understanding while relaxing ..... T F

46. I don't care very much whether other people like me or the way I do things ..... T F

47. I usually try to get just what I want for myself because it is not possible to satisfy everyone anyway ..... T F

48. I have no patience with people who don't accept my views ..... T F

49. I don't seem to understand most people very well ..... T F

50. You don't have to be dishonest to succeed in business ..... T F

51. I sometimes feel so connected to nature that everything seems to be part of one living organism ..... T F

52. In conversations I am much better as a listener than as a talker ..... T F

53. I lose my temper more quickly than most people ..... T F

54. When I have to meet a group of strangers, I am more shy than most people ..... T F

55. I am more sentimental than most people ..... T F

56. I seem to have a "sixth sense" that sometimes allows me to know what is going to happen ..... T F

57. When someone hurts me in any way, I usually try to get even ..... T F

58. My attitudes are determined largely by influences outside my control ..... T F

59. Each day I try to take another step toward my goals ..... T F

60. I often wish I was stronger than everyone else ..... T F

61. I like to think about things for a long time before I make a decision ..... T F

62. I am more hard-working than most people ..... T F

63. I often need naps or extra rest periods because I get tired so easily ..... T F

64. I like to be of service to others ..... T F

65. Regardless of any temporary problem that I have to overcome, I always think it will turn out well ..... T F

66. It is hard for me to enjoy spending money on myself, even when I have saved plenty of money ..... T F

67. I usually stay calm and secure in situations that most people would find physically dangerous ..... T F

68. I like to keep my problems to myself ..... T F

69. I am often troubled by the difficulties I have dealing with others ..... T F

70. I like to stay at home better than to travel or explore new places ..... T F

71. I do not think it is smart to help weak people who cannot help themselves ..... T F

72. I cannot have any peace of mind if I treat other people unfairly, even if they are unfair to me ..... T F

73. People will usually tell me how they feel ..... T F

74. I often wish I could stay young forever ..... T F

75. Sometimes I get upset ..... T F

76. Sometimes I have felt like I was part of something with no limits or boundaries in time or space ..... T F

77. I sometimes feel a spiritual connection to other people that I cannot explain in words ..... T F

78. I try to be considerate of other people's feeling, even when they have been unfair to me in the past ..... T F

79. I like it when people can do whatever they want without strict rules and regulations ..... T F

80. I would probably stay relaxed and outgoing when meeting a group of strangers, even if I were told they are unfriendly ..... T F

81. Usually I am more worried than most people that something might go wrong in the future ..... T F

82. I usually think about all the facts in detail before I make a decision ..... T F

83. I feel it is more important to be sympathetic and understanding of other people than to be practical and tough-minded ..... T F

84. I often feel a strong sense of unity with all the things around me ..... T F

85. I often wish I had special powers like Superman ..... T F

86. Other people control me too much ..... T F

87. I like to share what I have learned with other people ..... T F

88. Religious experiences have helped me to understand the real purpose of my life ..... T F

89. I often learn a lot from people ..... T F

90. Repeated practice has allowed me to become good at many things that help me to be successful ..... T F

91. I am usually able to get other people to believe me, even when I know that what I am saying is exaggerated or untrue ..... T F

92. I need much extra rest, support, or reassurance to recover from minor illnesses or stress ..... T F

93. I know there are principles for living that no one can violate without suffering in the long run ..... T F

94. I don't want to be richer than everyone else ..... T F

95. I would gladly risk my own life to make the world a better place ..... T F

96. Even after thinking about something a long time, I have learned to trust my feelings more than my logical reasons ..... T F

97. Sometimes I have felt my life was being directed by a spiritual force greater than any human being ..... T F

98. I usually enjoy being mean to anyone who has been mean to me ..... T F

99. I have a reputation as someone who is very practical and does not act on emotion ..... T F

100. It is easy for me to organise my thoughts while talking to someone ..... T F

101. I haven't got as far as I'd like to in life because of the kind of person I am ..... T F

102. I am strongly moved by sentimental appeals (like when asked to help crippled children) ..... T F

103. I usually push myself harder than most people do because I want to do as well as I possibly can ..... T F

104. I have so many faults that I don't like myself very much ..... T F

105. I have too little time to look for long-term solutions for my problems ..... T F

106. I often cannot deal with problems because I just don't know what to do ..... T F

107. I often wish I could stop the passage of time ..... T F

108. I hate to make decisions based only on my first impressions ..... T F

109. I prefer spending money rather than saving it ..... T F

110. I can usually do a good job of stretching the truth to tell a funnier story or to play a joke on someone ..... T F

111. Occasionally I talk about people behind their backs ..... T F

112. If I am embarrassed or humiliated, I get over it very quickly.....T F

113. It is extremely difficult for me to adjust to changes in my usual way of doing things because I get so tense, tired, or worried.....T F

114. I usually demand very good practical reasons before I am willing to change my old ways of doing things.....T F

115. I need a lot of help from other people to train me to have good habits.....T F

116. I think that extra-sensory perception (ESP like telepathy or precognition) is really possible.....T F

117. I would like to have warm and close friends with me most of the time.....T F

118. A nuclear war may not be such a bad idea.....T F

119. I nearly always stay relaxed and carefree, even when nearly everyone else is fearful.....T F

120. I find sad songs and movies pretty boring.....T F

121. Circumstances often force me to do things against my will.....T F

122. It is hard for me to tolerate people who are different from me.....T F

123. I think that most things that are called miracles are just chance.....T F

124. I would rather be kind than get revenge when someone hurts me.....T F

125. I often become so fascinated with what I'm doing that I get lost in the moment -- like I'm detached from time and place.....T F

126. I do not think I have a real sense of purpose for my life.....T F

127. I try to cooperate with others as much as possible.....T F

128. I am satisfied with my accomplishments, and have little desire to do better.....T F

129. I often feel tense and worried in unfamiliar situations, even when others feel there is no danger at all.....T F

130. I often follow my instincts, hunches, or intuition without thinking through all the details.....T F

131. Other people often think that I am too independent because I won't do what they want.....T F

132. I often feel a strong spiritual or emotional connection with all the people around me.....T F

133. It is usually easy for me to like those people who have different values from me.....T F

134. Other people often seem bothered by the things I do or say.....T F

135. Good habits have become "second nature" to me -- they are automatic and spontaneous actions nearly all the time.....T F

136. I don't mind the fact that other people often know more than I do about something.....T F

137. I usually try to imagine myself "in other people's shoes", so I can really understand them.....T F

138. Principles like fairness and honesty have little role in some aspects of my life.....T F

139. I am better at saving money than most people.....T F

140. I have never told a lie.....T F

141. Even when most people feel it is not important, I often insist on things being done in a strict and orderly way ..... T F

142. I feel very confident and sure of myself in almost all social situations ..... T F

143. My friends find it hard to know my feelings because I seldom tell them about my private thoughts ..... T F

144. I hate to change the way I do things, even if many people tell me there is a new and better way to do it ..... T F

145. I think it is unwise to believe in things that cannot be explained scientifically ..... T F

146. I like to imagine my enemies suffering ..... T F

147. I am more energetic and tire less quickly than most people ..... T F

148. I like to pay close attention to details in everything I do ..... T F

149. I often stop what I am doing because I get worried, even when my friends tell me everything will go well ..... T F

150. I often wish I was more powerful than everyone else ..... T F

151. I usually am free to choose what I will do ..... T F

152. Often I become so involved in what I am doing that I forget where I am for a while ..... T F

153. Members of a team rarely get their fair share ..... T F

154. Most of the time I would prefer to do something risky (like hang-gliding or parachute jumping), rather than having to stay quiet and inactive for a few hours ..... T F

155. Because I so often spend too much money on impulse, it is hard for me to save money, even for special plans like a vacation ..... T F

156. I don't go out of my way to please other people ..... T F

157. I am not shy with strangers at all ..... T F

158. I often give in to the wishes of friends ..... T F

159. I spend most of my time doing things that seem necessary but not really important to me ..... T F

160. I don't think that religious or ethical principles about what is right and wrong should have much influence in business decisions ..... T F

161. I often try to put aside my own judgments so that I can better understand what other people are experiencing ..... T F

162. Many of my habits make it hard for me to accomplish worthwhile goals ..... T F

163. I have made real personal sacrifices in order to make the world a better place – like trying to prevent war, poverty and injustice ..... T F

164. I never worry about terrible things that might happen in the future ..... T F

165. I almost never get so excited that I lose control of myself ..... T F

166. I often give up a job if it takes much longer than I thought it would ..... T F

167. I prefer to start conversations, rather than waiting for others to talk to me ..... T F

168. Most of the time I quickly forgive anyone who does me wrong ..... T F

169. My actions are determined largely by influences outside my control ..... T F

170. The way I behave often gets me into trouble on the job, at school or at home ..... T F

171. I prefer to wait for someone else to take the lead in getting things done ..... T F

172. I usually respect the opinions of others ..... T F

173. I have had experiences that made my role in life so clear to me that I felt very excited and happy ..... T F

174. It is fun for me to buy things for myself ..... T F

175. I believe that I have experienced extra-sensory perception myself ..... T F

176. I believe that my brain is not working properly ..... T F

177. My behaviour is strongly guided by certain goals that I have set for my life ..... T F

178. It is usually foolish to promote the success of other people ..... T F

179. I often wish I could live forever ..... T F

180. I usually like to stay cool and detached from other people ..... T F

181. I am more likely to cry at a sad movie than most people ..... T F

182. I recover more quickly than most people from minor illnesses or stress ..... T F

183. I often break rules and regulations when I think I can get away with it ..... T F

184. I need much more practice in developing good habits before I will be able to trust myself in many tempting situations ..... T F

185. I wish other people didn't talk as much as they do ..... T F

186. Everyone should be treated with dignity and respect, even if they seem to be unimportant or bad ..... T F

187. I like to make quick decisions so I can get on with what has to be done ..... T F

188. I usually have good luck in whatever I try to do ..... T F

189. I am usually confident that I can easily do things that most people would consider dangerous (such as driving an automobile fast on a wet or icy road) ..... T F

190. I am bothered by the kind of person I am ..... T F

191. I like to explore new ways to do things ..... T F

192. I enjoy saving money more than spending it on entertainment or thrills ..... T F

193. Individual rights are more important than the needs of any group ..... T F

194. I have had personal experiences in which I felt in contact with a divine and wonderful spiritual power ..... T F

195. I have had moments of great joy in which I suddenly had a clear, deep feeling of oneness with all that exists ..... T F

196. Good habits make it easier for me to do things the way I want ..... T F

197. Most people seem more resourceful than I am ..... T F

198. Other people and conditions are often to blame for my problems ..... T F

199. It gives me great pleasure to help others, even if they have treated me badly ..... T F

200. I often feel like I am a part of the spiritual force on which all life depends ..... T F

201. Even when I am with friends, I prefer not to "open up" very much ..... T F

202. I usually can stay "on the go" all day without having to push myself ..... T F

203. I nearly always think about all the facts in detail before I make a decision, even when other people demand a quick decision ..... T F

204. I am not very good at talking my way out of trouble when I am caught doing something wrong ..... T F

205. I am more of a perfectionist than most people ..... T F

206. Whether something is right or wrong is just a matter of opinion ..... T F

207. I think my natural responses now are usually consistent with my principles and long-term goals ..... T F

208. I believe that all life depends on some spiritual order or power that cannot be completely explained ..... T F

209. I think I would stay confident and relaxed when meeting strangers, even if I were told they are angry at me ..... T F

210. People find it easy to come to me for help, sympathy, and warm understanding ..... T F

211. I am slower than most people to get excited about new ideas and activities ..... T F

212. I have trouble telling a lie, even when it is meant to spare someone else's feelings ..... T F

213. There are some people I don't like ..... T F

214. I don't want to be more admired than everyone else ..... T F

215. Often when I look at an ordinary thing, something wonderful happens -- I get the feeling that I am seeing it fresh for the first time ..... T F

216. Most people I know look out only for themselves, no matter who else gets hurt ..... T F

217. I usually feel tense and worried when I have to do something new and unfamiliar ..... T F

218. I often push myself to the point of exhaustion or try to do more than I really can ..... T F

219. Some people think I am too stingy or tight with my money ..... T F

220. Reports of mystical experiences are probably just wishful thinking ..... T F

221. My will power is too weak to overcome very strong temptations, even if I know I will suffer as a consequence ..... T F

222. I hate to see anyone suffer ..... T F

223. I know what I want to do in my life ..... T F

224. I regularly take time to consider whether what I am doing is right or wrong ..... T F

225. Things often go wrong for me unless I am very careful ..... T F

226. If I am feeling upset, I usually feel better around friends than when left alone ..... T F

227. I don't think it is possible for one person to share feelings with someone else who hasn't had the same experiences ..... T F

228. It often seems to other people like I am in another world because I am so completely unaware of things going on around me ..... T F

229. I wish I were better looking than everyone else ..... T F

230. I have lied a lot on this questionnaire ..... T F

231. I usually stay away from social situations where I would have to meet strangers, even if I am assured that they will be friendly ..... T F

232. I love the blooming of flowers in the spring as much as seeing an old friend again ..... T F

233. I usually look at a difficult situation as a challenge or opportunity ..... T F

234. People involved with me have to learn how to do things my way ..... T F

235. Dishonesty only causes problems if you get caught ..... T F

236. I usually feel much more confident and energetic than most people, even after minor illnesses or stress ..... T F

237. I like to read everything when I am asked to sign any papers ..... T F

238. When nothing new is happening, I usually start looking for something that is thrilling or exciting ..... T F

APPENDIX (d)

PERSONALITY TRAITS AND THE APPROPRIATE DETECTION OF PRISONERS.

The participant sample was divided into four groups according to mental health status and accurate detection. The four groups were;

- (1) detected (i.e., appropriately referred) mentally disordered prisoners (DMD)
- (2) non-detected (i.e., inappropriately not referred) mentally disordered prisoners (NDMD)
- (3) detected (i.e., appropriately not referred) non-mentally disordered prisoners (DNMD)
- (4) non-detected (i.e. inappropriately referred) non-mentally disordered prisoners (NDNMD)[1]

The TCI was used to measure the participants personality traits, and individual 3(group) X 1(scale) analysis of variance were calculated on the seven dimensions of this inventory. The mean total scores and standard deviations for each group on the TCI dimensions are presented in Table 10. The validity of the analysis of variance was confirmed by Newman-Keuls pairwise comparisons. Harm avoidance was the only dimension of the TCI that showed a significant difference across and between the three groups, $F(2, 92)=14.05$, $p=0.0001$. Group 3 (DNMD) recorded significantly lower scores than group 2 (NDMD), who in turn recorded significantly lower scores than group 1 (DMD). There was a significant difference across groups on the self-directedness and self-transcendence dimensions, $F(2, 92)=9.49$, $p=0.0002$ and $F(2, 92)=3.14$, $p=0.04$ respectively. On both these dimensions group 3 (DNMD) recorded significantly different scores from groups 1 (DMD) and 2 (NDMD), who did not differ from each other. There was a significant difference found across the three groups on the

[1]Group 4 was dropped from this part of the analysis because there was only one participant in this category.

cooperativeness dimension of the TCI, F(2, 92)=3.56, p=0.03. Group 1 (DMD) recorded significantly higher scores than both group 2 (NDMD) and group 3 (DNMD), who did not differ from each other. The novelty seeking dimension of the TCI did not show a significant difference across the three groups, F (2, 92)=1.75, p=0.18. However, when the scores for the four novelty seeking sub-scales were analysed, the first sub-scale (exploratory excitability versus stoic rigidity) revealed a significant difference across groups F(2, 92)=3.96, p=0.02. This finding was similar to that of the cooperativeness dimension in that group 1 (DMD) recorded significantly different scores than groups 2 (DNMD) and 3 (NDMD), who did not differ from each other. The persistence and reward dependence dimensions were not significantly different across the three groups F(2, 92)=0.05, ns and F(2, 92)=0.80, ns, respectively. When the scores for the three reward dependence sub-scales were analysed, no individual sub scale showed a significant difference between the three groups.

THE MEAN TOTAL SCORES FOR EACH GROUP ON THE TCI DIMENSIONS.

TCI Dimensions	*Group 1*		*Group 2*		*Group 3*		
	M	**SD**	**M**	**SD**	**M**	**SD**	**F Value[2]**
Novelty Seeking	22.0	4.7	24.4	5.5	23.4	4.4	1.75
Novelty Seeking sub scale one	5.3	1.5	6.5	2.0	6.3	1.5	3.96*
Harm Avoidance	20.0	5.9	15.7	6.5	11.5	5.8	14.05****
Reward Dependence	10.6	4.1	10.6	5.1	9.3	5.6	0.80
Persistence	4.4	2.1	4.3	1.8	4.5	1.7	0.05
Self-directedness	20.9	6.2	23.2	9.2	29.1	6.5	9.49***
Cooperativeness	26.4	6.5	20.9	9.8	20.8	8.9	3.56*
Self-Transcendence	17.3	7.4	16.5	6.7	13.2	6.6	3.14*

[2] *p=0.05>0.01, **p=0.01>0.001, ***p=0.001>0.0001, ****p=0.0001